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AUTHOR

Laurel K Cobb, John L Fiedler Petra Reyes Jose Romero

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Laurel K Cobb
John L Fiedler
Petra Reyes
Jose Romero

Fieldwork

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Edited and Produced by

BHM International
8403 Colesville Rd
Suite 805
Silver Spring, Maryland 20910
Phone 301-565-2205 ext 118
Fax 301-565-0281

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ACRONYMS

USAID	United States Agency for International Development (USAID/W, USAID/Peru)
AIEPI	Atencion Integral en Programas Infantil, (The WHO Sick Child Initiative)
ARI	Acute Respiratory Infections
BHNP	Basic Health and Nutrition Project (of the World Bank)
CARE	Cooperative for American Relief Everywhere
CC	Health Training Center (PCMI)
CESAN	Consortio ESAN (ESAN Consortium)
CIUP	Centro de Investigaciones de la Universidad del Pacifico (Universidad Pacifica Research Center)
CTAR	Consejo Transitorio de Administracion Regional (Temporary Regional Administration Council)
CLAP	Latin American Center for Perinatology (Centro Latinoamericano de Perinatologia)
CLASS	Comite Local de Administracion de Servicios de Salud (Local Committee of the Administration of Services)
CP	Condition Precedent
CQI	Continuous Quality Improvement
CS	Child Survival
DDC	Diarrheal Disease Control
DIGEMID	General Directorate of Medicines, Inputs and Drugs (Direccion General de Medicamentos, Insumos y Drogas)
DIRES	Direccion Regional de Salud (Regional Health Directorate)
DMIM	Decentralized Management Implementation Model
EAT	Technical Assistance Team
EEU	European Economic Union
ENDES	National Demographic and Family Health Survey (Encuesta Nacional Demografica y de Salud Familiar)
ENNSA	National Nutritional and Health Survey (Encuesta Nacional de Nutricion y Salud)
EPI	Expanded Program of Immunizations
ESAN	School of Business Administration (Escuela Superior de Administraci3n de Negocios)
GDP	Gross Domestic Product
GNP	Gross National Product
GoP	Government of Peru
GRADE	Grupo de Analisis para el Desarrollo (Analysis Group for Development)
GTZ	German Technical Assistance Agency
HC	Hospital Training Center (PCMI)
HCC	Host Country Contribution
HIS/MIS	Health Information System/Management Information System
HPN	Health, Population and Nutrition Office
IBRD	International Bank for Reconstruction and Development (World Bank)
ICC	Interagency Coordinating Committee
IC	Institutional Contractor
IDB	Interamerican Development Bank
IEC	Information, Education and Communication

IIN	Nutrition Research Institute
IMR	Infant Mortality Rate
IPSS	Peruvian Institute of Social Security
JICA	Japanese International Cooperating Agency
KAP	Knowledge, Attitudes and Practices
MCH	Maternal and Child Health
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MSH	Management Sciences for Health
MTP	Management, Training, Planning
ODA	Overseas Development Agency, Great Britain
OFICE	Office of Financing, Investment and External Cooperation (Oficina de Financiamiento, Inversiones y Cooperacion Externa)
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PFSS	Programa de Fortalecimiento de Servicios de Salud (Strengthening Health Services Program)
PSNB	Proyecto de Salud y Nutricion Basica (Basic Health and Nutrition Project)
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
PAI	Expanded Program of Immunizations
PANFAR	Programa de Alimentacion y Nutricion para Familias en Alto Riesgo (Food and Nutrition Program for High Risk Families)
PASARE	Reproductive Health Assistance Plan
PHC	Primary Health Care
PHR	Partnerships for Health Reform
PID	Project Identification Document
PIL	Project Implementation Letter
PIMI	Integrated Maternal Infant Program (Programa Integrado Materno-Infantil)
PL-480	Public Law 480
PP	Project Paper
PRISMA	Projects in Information, Health, Medicine and Agriculture
REPROSALUD	Reproductive Health in the Community
SIAF	Sistema Integrado de Administracion Financiera (Integrated Financial Administration System)
SICI	Sistema Informatica de Costos e Ingresos (Cost and Income Information System)
SHIP	Strengthening Health Institutions Project
SHSP	Strengthening Health Services Program (SHSP) (of the IDB)
SILOMED	Sistema Local de Medicamentos (Local Medicine System)
SPP	Sistema de Programacion y Presupuesto (Budget Programming System)
TB	Tuberculosis
TQM	Total Quality Management
UDES	Health Department (Unidad Departamental de Salud)
UEP	Special Project Unit
UTES	Health Territories (Unidad Territorial de Salud)
VEA	Active Epidemiological Surveillance (Vigilancia Epidemiologica Activa)
WHO	World Health Organization
ZONADIS	Zone for Integrated Health Development (Zona de Desarrollo Integral de Salud)

EXECUTIVE SUMMARY

This is a report on the mid-term evaluation of PROJECT 2000 (No 527-0366), a seven year \$30 million Project, complemented by GOP counterpart funds, and implemented under a bilateral agreement signed between the Governments of Peru (GOP) and the United States of America on September 29, 1993. A four-person team undertook the evaluation in March and April of 1999. The objectives were to 1) assess progress toward achievements of Project objectives and identify and analyze the reasons of any shortfall and make recommendations as to how the Institutional Contractor, the Ministry of Health (MoH), and USAID can improve their management and involvement in the Project, 2) evaluate the financial, institutional and social sustainability of the Project and make recommendations to enhance significant progress in all three by the end of Project life, 3) analyze the Project's resources, budgets, and timeframe, and assess any future need for modifications, and 4) identify any other factor that may have had a positive or negative impact on Project implementation.

The goal of PROJECT 2000 is to improve the health and nutritional status of young children and women of childbearing age, the purpose of the Project is to increase the use of child and maternal health interventions. To achieve its goal and purpose, the Project design was designed with a three-pronged approach: 1) provision of support directly to child and maternal health services, (2) improvement of the efficiency of those services through improved management, and 3) support for the financial sustainability of those services through improved health financing. As a way of focusing USAID-supported interventions and rationalizing donor resources in Peru, PROJECT 2000 targets twelve geographic areas: Ayacucho, Chavin, Chanka-Andahuaylas, Huancavelica, Ica, La Libertad, Lima-East, Moquegua, Puno, San Martin, Tacna, and Ucayali.

PROJECT 2000, for which USAID has authorized \$30 million, obligated \$18.8 million and expended \$13.4 million through FY 98, is jointly funded by the GOP which expended \$9.78 million of PL-480 funds and \$11.9 million of GOP treasury funds from the Project's commencement through FY 98. An Institutional Contractor (IC), Pathfinder International, who was selected in December 1994 through competitive bidding via a selection committee comprised of representatives of both the MoH and USAID, is responsible for implementation of Project activities under the direction of USAID and the MoH.

Progress Toward Achievements of Project Objectives

PROJECT 2000 has evolved considerably since it was designed six years ago. While the Project goal, purpose, and objectives have not changed, the currently planned outputs (principally functional outputs and process activities) are very different from the service utilization and service outputs projected in the design as leading to the achievement of Project objectives. With the evolution of the Project, the Project's objectives and scope must be modified; they will not be achieved, by the current outputs, in the manner and scope anticipated. Additionally, service utilization and service outputs need to be formulated to link the functional and process activities with anticipated changes in utilization of health services, health status and sustainability.

The notable success of PROJECT 2000 is the PCMI, the training/service quality program in reproductive, maternal, perinatal and child health. In PCMI, PROJECT 2000 is piloting a model combining innovative approaches to human resources development and quality improvement for MCH services in 89 health establishments in the twelve targeted regions of Peru. Phase one is proceeding successfully at the basic qualification level, and is showing evidence of improving quality of MCH services and increasing

utilization of those services. The PCMI is now at a critical juncture for determining program thrust for the next program pilot phase - "vertical" increases in levels of quality versus "horizontal" spread of minimal quality improvements to the 2,500 establishments in those regions.

To support the PCMI, PROJECT 2000 has improved drug management, evaluated the national health information system, and developed supervisory approaches for the PCMI program in the 89 hospitals. An Information, Education and Communication (IEC) component to the Project started late and has been relatively weak to date. In the Project extension recommended by the evaluation, IEC would be strengthened.

PROJECT 2000 had financial management and health financing components that got off to a slow start. Some activities have been dropped. The Budget Programming System (SPP) is undoubtedly the most significant output; it is a powerful and flexible electronic spreadsheet-based software program that can be used to estimate both the unit costs and the total costs of all MoH health facility activities. This system represents an important break with the top-down way goals were established and budget requests developed in the past. The second significant output is the Cost and Income Information System (SICI). This step-down cost analysis software tool has been developed and implemented by PROJECT 2000 in three hospitals (Huaras, Ayacucho and San Martin) and introduced the five service networks funded by the Bank's basic health project. The SICI system is designed to be compatible with the SPP.

Financial, Institutional and Social Sustainability,

There are a number of indicators of the potential sustainability of the two key financial management systems (SPP and SICI) developed by PROJECT 2000. To date, however, there has been inadequate networking with Ministry of Economy and Finance (MEF) who appear interested and supportive of both; they need, however, to be brought into the process to better ensure that the systems are designed in a manner that is consistent with MEF's needs and requirements. This would greatly enhance the sustainability of both of these activities.

An important question for the evaluation team was the financial sustainability of the PCMI. Unfortunately, PROJECT 2000 did not have the necessary data that would have enabled the team to breakout start-up and recurrent costs. It is noteworthy, however, in a consideration of financial sustainability, that while there has been a shortfall of PL-480 funding, the GOP and the MoH have more than offset this shortfall with public treasury financing. Total counterpart funding has exceeded the level stipulated in the GOP-USAID Project Agreement. The MoH's widespread interest in and universally enthusiastic support for the PCMI, together with the MoH's significant financial contribution to the Project augur well for the financial sustainability of the Project's interventions.

The prospect of institutional sustainability of the PCMI appears strong. On the operational level of individual service institutions, the potential for sustainability is excellent. Regional authorities, hospital directors and service providers "own" the improvements. They point to renovated facilities, improved client satisfaction, better case management and increased service volume and say "We did this. This is the result of our problem-solving, our efforts and our concern."

Patients and their families are recognizing and appreciating the positive changes in PCMI-assisted hospitals; much more work is needed, however, before communities are knowledgeable about healthy behaviors, danger signs, when to seek help and routinely demand high quality maternal and child health services.

The Project's Resources, Budgets, And Timeframe

The Project's rate of expenditure of grant monies was relatively slow in its first two years, owing to major modifications that were made in the design of the core activities of the Project, viz , the content and approach of the PCMI. While the Pathfinder contract was signed in December 1994, and Pathfinder began working on the Project in April 1995, it was not until May of 1996 that there was agreement on what PCMI would consist of. It was not until September 1996 that the sub-contract with Consorcio ESAN, which has led the PCMI, was signed. The roll out of the PCMI, therefore, began only a little more than 1 5 years ago. It is estimated that the PCMI component of PROJECT 2000 is currently about two years behind the training implementation schedule.

The evaluation team recommends the Project be extended and that funding to Pathfinder International be extended through December 2001, plus time for closeout.

Other Factors Influencing Project Implementation

Two factors influencing Project implementation relate to the structure of the Project and the relationships between the three key parties in PROJECT 2000: USAID, the MoH and the IC. These factors have led to delays, and lead to continuing conflict within the Project. The first factor is the complex structure of the Project and the multiplicity of parties. The MoH counterpart to the IC is a Special MoH Unit (UEP 2000 2000) that reports to the Office of Financing, Investment and External Cooperation of the MoH, rather than to the MoH line departments of maternal and child health. The IC itself has two main subcontractors that, in turn, have further subcontracts.

Secondly, the Project Agreement and the contract between the USAID and the IC state that the MoH will personally approve all Project documents that authorize procurement of services and will participate fully with A I D in guiding and monitoring the Project. The UEP 2000 understands this language literally. They understand that they are authorized by this language to review every prospective purchase of services on the part of the IC, regardless of the cost, and that their approval, or denial thereof, of the prospective purchase should be based upon a serious review of the line items in that document. The result is delay and friction.

Recommendations

The team has made a great many recommendations as to how the IC, the MoH, and USAID can improve their management and involvement in this Project, enhance the financial, institutional and social sustainability of the Project, modify activities to more fully achieve the projected outputs. These recommendations are compiled together in ANNEX 1 of the report.

1 BACKGROUND

1.1 Goal, Purpose, and Components¹

PROJECT 2000 (No 527-0366) is implemented under a bilateral agreement signed between the Governments of Peru (GOP) and the United States of America on September 29, 1993. The goal of this seven-year US\$ 30-million grant, complemented by GOP counterpart funds², is to improve the health and nutritional status of young children and women of childbearing age. The purpose of the Project is to increase the use of child and maternal health interventions. The Project was designed to increase appropriate use of child and maternal health interventions while, through community-based promotive and preventive activities, it would decrease the need for curative care, thus contributing to a greater efficiency in facility-based services. The Project also was designed to address issues of sustainability, believing that higher levels of appropriate utilization could be achieved only if services were made more sustainable by becoming more available, accessible and, acceptable. To achieve its goal and purpose, the Project design was designed with a three-pronged approach: 1) provision of support directly to child and maternal health services, (2) improvement of the efficiency of those services through improved management, and 3) support for the financial sustainability of those services through improved health financing.

As a way of focusing USAID-supported interventions and rationalizing donor resources in Peru, PROJECT 2000 targets twelve geographic areas: Ayacucho, Chavin, Chanka-Andahuaylas, Huancavelica, Ica, La Libertad, Lima-East, Moquegua, Puno, San Martin, Tacna, and Ucayali.

To facilitate Project management and ensure appropriate technical assistance, the main Project activities are being implemented through an Institutional Contractor (IC), Pathfinder International, who relies on overall policy and technical guidance from the Ministry of Health (MoH) and USAID/Peru. The IC was selected in December 1994, through competitive bidding, via a selection committee comprised of representatives of both the MoH and USAID.

Most Project technical and financial resources have been devoted to the first component - Strengthening Child and Maternal Health Services - which was designed to provide assistance to priority health and nutrition programs and was expected to result in a visible reduction in infant, young child and maternal deaths, as well as improvements in nutritional status. USAID and the MoH designed the other two components as "enabling" components that would contribute to the long-term viability of child and maternal health services and help ensure the future of those services.

The first Project component, Strengthening Child and Maternal Health Services, was designed to expand the coverage and improve the quality of national child and maternal and perinatal health programs, pregnancy and delivery care, acute respiratory infections, with emphasis on pneumonia, infant and young child nutrition, immunization and diarrheal diseases. Because existing child survival programs in Peru had appreciably reduced infant deaths due to immuno-preventable and diarrheal diseases, PROJECT 2000 was to place the greatest emphasis on programs that would target the major killers at the time of Project design - perinatal complications and acute respiratory diseases, as well as on malnutrition - as major contributing causes of mortality and a serious impediment to child growth and development. PROJECT 2000 was not to place great emphasis on strengthening family planning services because other USAID

¹ Taken from the Evaluation Scope of Work

² 1994-1998 expenditures

USAID US\$ 14 million

GOP PL-480 of \$9.78 and GOP treasury of \$11.95 million

activities are providing assistance to the Family Planning Program of the MoH. These are the centrally funded USAID Projects working together in Peru as the PASARE Program (Reproductive Health Assistance Plan) and Cobertura con Calidad (public sector support)

The second Project component, Initiatives for Efficient Management, was designed to help decentralize administration, and to improve the management of resources and budget levels for child and maternal health programs. To support this component, the IC was charged with developing pilot activities in the Project priority areas in decentralized management improvement and total quality management, all of which were to be geared toward increasing the quality and efficiency of health care services. In addition, under this component the IC was charged with introducing a cost-based programming and budgeting process into the MoH that would help the MoH rationalize its budget requests and disbursements. Finally, under this component the Project was to provide short-term and long-term training opportunities in public health and program management.

The third component, Health Care Financing, was designed to support MoH efforts to augment resources for primary health care through increased mobilization of funds and strengthened efficiency. Among other issues, it was to strive to increase the amount of the public sector budget available for child and maternal health services. This and such other issues as decentralization, the budget allocation process, budgetary segmentation, cost recovery and possibilities for public/private sector collaboration were to be addressed through policy dialogue with relevant GOP entities and health sector donors. Other efforts related to cost recovery and equity of service provision to low-income populations were to focus on the development of rational user fee and cost-recovery systems. Studies on cost analysis of health services and on health care demand would help the IC make recommendations for user fees, fee exemption criteria and cost-containment mechanisms.

1.2 Role of PROJECT 2000 in the USAID Portfolio

PROJECT 2000 is one of ten projects in the portfolio of the Health, Population and Nutrition Office (HPN) of USAID/Peru. It is the largest, at an authorized \$30 million, and one of the three considered by USAID/Peru to be most important and complementary. The other two Projects are Reproductive Health in the Community (REPROSALUD) and PASARE. REPROSALUD seeks to simultaneously improve the reproductive health status of poor Peruvian women and meet their strategic gender needs. It has four components: community dialogue and diagnosis, subgrants, advocacy, information dissemination and consumer education, and health-focused innovative activities. Through PASARE, the coordinated efforts of fourteen Cooperating Agencies funded by USAID/Washington's Global Bureau, USAID provides technical and financial assistance to the MoH in service delivery, management systems, information, education and communication (IEC), evaluation, and research.³

1.3 The Unidad Especial Proyecto 2000 (UEP 2000 2000)

The Unidad Especial Proyecto 2000 (UEP 2000 2000) or Special Unit for PROJECT 2000 is the counterpart designated by the MoH for USAID's PROJECT 2000. The designation of a special unit, outside the line MoH departments to be the counterpart, results, at least in part, from a December 1993 institutional analysis of the MoH. That analysis, conducted by USAID/Peru, concluded that it would be wise, given weak internal controls within the MoH, to have a special unit within the MoH, manage PROJECT 2000. In the following quote, taken from that report, the acronym for the MoH is the MDS:

³ USAID/Peru Office of Health, Population and Nutrition, Overview of Project Portfolio, July 1998

As a corollary of this institutional evaluation, we consider that given the internal control deficiencies in the different areas mentioned in the lines above, we are in the position to affirm that the best manner in which MDS could monitor the new project would be by means of a Special Unit to be established within MDS itself, which would dedicate itself exclusively to financial and pragmatic management of the project. It should also coordinate closely with the MEF Special Unit in the timely delivery of funds to the health Regions and follow-up on the application of the funds to the programs according to the budgets and/or operative plans. This Unit within MDS should have technical administrative advisory personnel at the central and regional levels in order to support the development of the new project's activities with the approval of the respective Health Program directors. MDE's Upper Directorate should assess this administration mechanism for the PROJECT 2000.⁴

The office and contracted staff of the UEP 2000, supported in part by USAID Project funds, are in the MoH, one floor apart from the Institutional Contractor.

2 THIS EVALUATION

2.1 Objectives

The Scope of Work (SOW) presented four objectives for this evaluation (ANNEX 2). "First, the evaluation will assess progress toward achievements of Project objectives and identify and analyze the reasons of any shortfall. This calls for an evaluation of the changing environment and conditions and an assessment of whether the IC, the MoH, and USAID have acted adequately in their respective roles to those changes. Furthermore, the evaluation team will make recommendations as to how the IC, the MoH, and USAID can improve their management and involvement in this Project. The second objective of the evaluation is to evaluate the financial, institutional, and social sustainability of the Project and make recommendations to enhance significant progress in all three by the end of Project life. The third objective is to analyze the Project's resources, budgets, and timeframe, and assess any future need for modifications. The fourth objective is to identify any other factor that may have had a positive or negative impact on Project implementation."⁴

2.2 Outputs and Indicators

The SOW that is the basis for this evaluation presented the outputs identified in the contract signed between USAID/Peru and Pathfinder International in December 1994. USAID/Peru also gave the team a copy of text for a proposed revised contract that has been under discussion between USAID/Peru, Pathfinder International and the MoH for the past year. Contract revision has been stalled over the past year due to a number of issues.⁵ USAID instructed the team to use the outputs identified in the proposed revised contract, which USAID indicated the Minister formally approved shortly before the evaluation.⁶ We are using those outputs. After the team arrived in country, the IC developed and shared with the team a matrix listing outputs based upon the proposed revised contract and indicators related to those outputs (ANNEX 2).

⁴ USAID/Peru Scope of Work for the evaluation team.

⁵ One issue was the long process of documenting all the changes requested, another issue under discussion was the role of the MOH counterpart in the financial supervision and monitoring of the Pathfinder contract.

⁶ We did not see a copy of final revised contract.

Although the Project has revised outputs and indicators (at the output level) since the Project Paper, Logical Framework and USAID/Pathfinder contract was signed, the stated Project goal, purpose, scope, targets, approach and objectives have not changed. See the following two matrices that illustrate the current "disconnect" between the Project's scope, indicators and objectives on the one hand, and its currently anticipated outputs on the other hand.

Matrix 1 PROJECT 2000 Goal, Purpose, Scope, Approach and Objectives Logical Framework and Current Status		
Component	Logical Framework Design	Current Design
Goal	To improve the health and nutrition status of young children and women of childbearing age	to improve the health and nutrition status of young children and women of childbearing age
Purpose	To increase the use of child and maternal health interventions	to increase the use of child and maternal health interventions
Scope of Project	National (33 regions)	12 regions with a focus on 89 health establishments within the 2481 health establishments in those 12 regions
Indicators of success at purpose level	<ul style="list-style-type: none"> • Infant mortality rates disaggregated by age and cause, • Breastfeeding, weaning and growth monitoring rates • Immunization rates • Maternal-perinatal health, including family planning, rates • ARI and DDC rates 	No revision to date
Baseline and targets	1991 DHS and Projections for 1996	No update
Approach	"1) Providing support directly to child and maternal health services, 2) improving the efficiency of those services through improved management, 3) supporting the financial sustainability of those services through improved health financing	The three-pronged approach is phrased the same in the proposed revised contract
Components and objectives	Three components and objectives congruent with the approach above See the matrix below	Components and objectives are virtually identical in the proposed revised contract as they were in Project Paper, Logical Framework and Contract

To achieve the three objectives, the Logical Framework presents 40 outputs and indicators for those outputs. They include:

- "Functional outputs which measure the number of activities conducted in each functional area such as training or IEC"

- "Service outputs which measure the adequacy of the service delivery system in terms of access, quality of care and program image"
- "Service utilization which measures the extent to which the services are used" ⁷

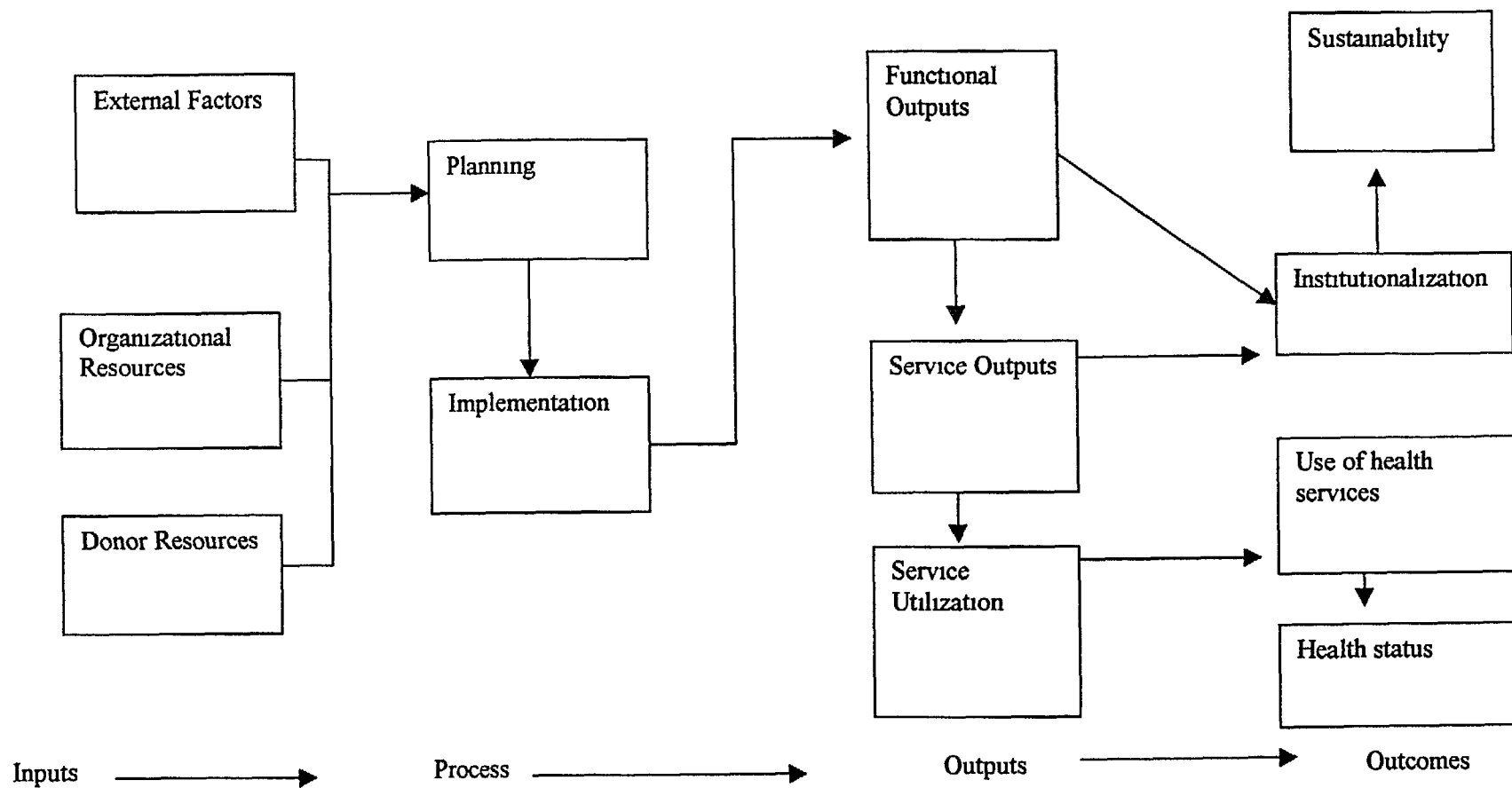
The proposed revised contract presents fifteen "principal outputs" and additional "major outputs", none of which are service outputs or service utilization. These include activities of planning and implementation that are at the process level, and functional outputs, a key one of which is the establishment of a training program in reproductive, maternal, perinatal and child health (PCMI). The indicators identified by the IC to assess these activities and outputs are a series of tasks. See the following matrix that illustrates the conceptual difference between process and outputs in a planning and evaluation framework.

There is a critical conceptual gap between the largely process-level activities currently identified by the PROJECT 2000 partners and the stated, outdated Project Objectives. This gap makes it difficult to respond to the SOW objective of assessing progress toward achievement of Project objectives. The simple answer to the SOW question about progress toward these objectives is

- No, the Project is not progressing to achieve those objectives on the scale or in the manner anticipated. The Project has evolved and USAID, the UEP 2000 and IC must update the objectives,
- The Project must develop a conceptual framework which links, through service utilization and service outputs, those new objectives with its currently anticipated outputs,
- However, the Project is accomplishing some outputs projected in the original design and has accomplished other activities - most notably the PCMI - that are discussed in this report.

⁷ Jane Bertrand and Amy Tsui, INDICATORS FOR REPRODUCTIVE HEALTH PROGRAM EVALUATION, page 14

Simplified Supply Conceptual Framework from Inputs to Impact⁸



⁸ IBID

Matrix X Project Components, Objectives and Outputs Logical Framework and Current Status			
Project Components	Objective	Logical Framework Outputs and Indicators	"Principal Outputs" in proposed revised contract
Strengthening Child and Maternal Health Services	to expand the coverage and improve the quality of national child and maternal health programs, including responsible parenthood, pregnancy and delivery care, acute respiratory infections, with emphasis on pneumonia, infant and young child nutrition, immunization and diarrheal diseases	<p>40 indicators related to the following outputs and sub-outputs</p> <ul style="list-style-type: none"> • Maternal-perinatal health, including family planning (5 sub-outputs and 12 indicators), example Pregnant women have adequate access to prenatal care - first prenatal visit will occur on average before the 4th month of pregnancy, rural women will receive on average 3 prenatal visits • ARI and pneumonia (2 sub-outputs and 4 indicators), example Early identification and diagnosis, and early treatment of children with pneumonia improve - 67% of ARI cases seen in health facilities will receive appropriate case management • Breastfeeding, weaning and growth monitoring (4 sub-outputs and 9 indicators), example Hospital practices that support the establishment of exclusive breastfeeding improve - 80% of MoH hospitals will have post-partum rooming in • Immunizations (3 sub-outputs and 4 indicators), example Children complete their vaccination series by age one - 80% of children will have reached their first birthday with complete immunizations • Diarrheal disease control (3 sub-outputs and 5 indicators), example Availability of ORS improves - 80% of health facilities will have ORS packets available • Information (1 sub-output and 2 indicators) Utilization of health information produced in the sector for decision-making is improved - 80% of local health units will be able to calculate and utilize selected indicators using the HIS/MIS system • Supervision (1 sub-output and 2 indicators) Supervision of MoH health facilities is strengthened - in at least 1 local health unit, a supervision system (that includes a subsystem of monitoring and quality control) of MoH health facilities, especially health center and health posts, will be implemented and evaluated • Logistics (1 sub-output and 1 indicator) Logistics system for medicines and other supplies in health services is improved - 50% of hospitals health centers, health posts community oral rehydration units will have some stock of each medicine appropriate to that level 	<ul style="list-style-type: none"> • Reports on formative research on the major health topics of the Project, with messages for the priority areas derived from this research • Establishment of a training program in reproductive maternal, perinatal and child health (PCMI) • Local-level IEC activities for the priority areas that encompass the maternal/child health topics of the Project • Self-instructional materials for health personnel and community-level health workers on maternal/child health topics • A continuing education bulletin or supplement to an existing publication that will keep MoH personnel current on maternal/child health topics • An evaluation of the presently functioning HIS <u>and the upgrading of this system</u> • Improved management of medicines in the 18 PCMI-related hospitals • An information system component, <u>integrated with the presently functioning HIS</u>, that tracks Project 2000 indicators within the priority areas • <u>A decentralized monitoring and supervisory system</u> • A total quality management improvement model piloted in 18 PCMI hospitals • A core group of MoH officials trained in the most current management practices in the field of public health • A tested design of a referral Maternal & Perinatal Care System

		<ul style="list-style-type: none"> • Physical Repairs (1 sub-output and 1 indicator) The physical state of repair of health centers and health posts is improved – 200 health centers and health posts will have basic repairs done 	
Initiatives for Efficient Management	Aims at decentralizing administration and improving the management of resources and budget levels for child and maternal health programs (contract and revised contract wording)	<ul style="list-style-type: none"> • Management (2 outputs and 4 indicators), example MoH increases the efficiency of planning for use of resources - budget categories will be rationalized 	<ul style="list-style-type: none"> • A national-level cost-based budget programming system • A decentralized management improvement model piloted in two hospitals • Quarterly coordination and evaluation meetings that include USAID, the MoH central office and program managers • Development and implementation of the Information System on Costs and Income (SICI)
Health Care Financing	to support MoH efforts to augment resources for primary health care through increased mobilization of funds and strengthened efficiency To increase the amount of the public sector budget available for child and maternal health services	<ul style="list-style-type: none"> • Financing (2 outputs and 4 indicators), Increased GOP resources are mobilized for priority child survival and maternal care programs – More than 55% of MoH services will be MCH, increased from 48% in 1990 	<ul style="list-style-type: none"> • A validated proposal for a user fee system for health services of the MoH • The results and recommendations of a series of studies on cost recovery

2.3 Methodology

The four-person evaluation team spent three and a half weeks in Peru, working closely with USAID, the UEP 2000 and IC. The UEP 2000 Project Director's secretary, who served the team as a logistics coordinator, identified important persons and institutions to contact and made arrangements for a very full itinerary. The team talked with a multitude of persons in the UEP 2000, regional and hospital managers, personnel of the IC and its subcontractors, staff of other donor agencies and with USAID. The team had one briefing meeting with three central-level MoH department directors. At the service delivery level, the team interviewed managers, service providers, patients and their husbands (ANNEX 3 - Persons contacted). We reviewed extensive documents, many of which the Mission sent to the team before arrival in Peru (ANNEX 4 -Bibliography).

The four-person team had a total of 16 person-days interviewing at the service delivery level, the time was shorter than desired due to the occurrence of Easter holidays within the evaluation's in-country time. Visits were made to hospitals and health centers in four regions: Puno (six hospitals and two health centers), Trujillo (three hospitals), Ayacucho (one hospital for financial systems only), San Martín (two hospitals, one health center, and one health post) and Lima East (one hospital and one health center). USAID, the UEP 2000, the IC and team decided which regions to visit based on time, security and program reasons, within those regions, the UEP 2000 selected the service units and prepared those units for the team's visit. Staff from USAID, the UEP 2000 and the Technical Assistance Team (EAT) of the IC accompanied team members as observers during interviews and commentators during the car journeys from one site to another. Within hospitals, team members interviewed hospital directors, health regional directors and deputy directors, service providers, IEC coordinators, pharmacy staff and patients (ANNEX 5 In-country Schedule).

There were several limitations in the fieldwork. Due to the short period in the field and the selection of sites, the team may have seen mainly the stronger PCMI-assisted regions and hospitals. The average time spent in each hospital, to interview staff and patients, was very short - ranging from a half-hour to two hours. The team had the opportunity to interview, for a total of an hour and a half, only three persons from the central MoH line departments responsible for maternal/perinatal health. However, the evaluation team (complete or partial) had meetings with five key Ministry of Health Directors, who are, and have been, the main counterparts of the Project.

3 THREE PARTNERS PERFORMANCE, STRUCTURE, AND COORDINATION

3.1 Introduction

The SOW stated *The evaluation team will assess the performance of (1) Pathfinder International as IC and technical assistance provider, (2) Ministry of Health (MoH) and regional health authorities in their role in general Project guidance, monitoring and supervision, and health services as implementing entities (3) USAID, as funding agency, in its support for implementation and monitoring of Project activities, coordination with the MoH and other donors since Project inception in September 1993*

The evaluation team shall evaluate the progress achieved to date in carrying out planned implementation tasks under each Project-supported MoH program and support system as stipulated in the Project Grant Agreement, Institutional Contractor Contract, Annual Operational Plans, Monthly and Annual Reports document the current status of each Project component/tasks, identify and analyze the reasons for any

shortfall, and provide recommendations to improve their implementation and add or delete specific components and tasks, if necessary

3 2 The Institutional Contractor

The Institutional Contractor, Pathfinder International, bid with CARE and Development Associates (DA) as subcontractors. In addition, there have been numerous other subcontracts to Pathfinder, CARE and DA. CARE has had a large subcontract with a four-member consortium led by ESAN, Escuela de Administracion de Negocios. The full team of the IC, known as the "Equipo de Asistencia Tecnica (EAT) or Technical Assistance Team began work in February 1995.

Although from an evaluation perspective it is desirable to identify separate inputs and attribute outputs to specific inputs (and institutions), the complex matrix structure of PROJECT 2000 makes it difficult to answer a number of evaluation questions, particularly those related to attribution and sustainability.

- Who is responsible for what?
- Who takes the credit for success? And the blame for failure?
- What did activities cost?
- Note that among the many parties contributing to the Project, only some of them are devoted full time to the Project. Among those who have contributed are

- Professional and administrative staff of the IC and its subcontractors
- Professional and administrative staff at the UEP 2000
- Professional and administrative staff at OFICE
- Professional and administrative staff at MoH, central level
- Professional and administrative staff in Regional Directors' offices
- Medical, technical and administrative staff at the PCMI hospitals

The current Project is very different from that projected in the Project Paper - in some ways, disappointingly short of what was projected. However, there has been a great deal of change since the Project was designed and much of what was presented in the Project Paper seems, in retrospect, unrealistic (scope of the Project including all the systems), based upon faulty knowledge (state of the national health information system for example), or outdated (interest in financial reform). However, there are significant contributions in PROJECT 2000, and the IC and all the parties listed above have contributed to those achievements.

There is one consistent complaint about Pathfinder International's performance, however, that must be raised. Pathfinder International in its proposal bid a great many accomplished international professionals. USAID and the MoH believe Pathfinder has not delivered adequately of that technical expertise -- supposed to be centered in Boston and available to support Pathfinder's programs internationally. They note that with the exception of an excellent Quality of Care Boston-based staff person, Boston has given little technical support to PROJECT 2000, instead the IC has developed a series of contracts with other institutions, both Peruvian and USA based. It would not be effective or efficient to change the structure at this point, however, both Pathfinder International and USAID/Peru would be wise to learn from this experience that has been frustrating to USAID and the MoH.

As the following pages indicate, there is a great deal to be accomplished before the achievements of PROJECT 2000 are financially and institutionally sustainable. Two additional years are necessary to carry out the recommendations in this report.

Recommendation

Extend funding to Pathfinder International to December 2001 (plus time for closeout) to enable the full development/completion of the activities presented in this report

3.3 The UEP 2000, the MoH Project Unit

The SOW asked the team to "assess the performance of the MoH Project Unit in fulfilling their Project implementation responsibilities in terms of the following liaison with USAID/HPN in formulating overall Project policy and making major Project management decisions, providing guidance to the IC in Project implementation, and coordination with the IC in the financing of Project activities in regions, ensuring that Project activities are carried out by the MoH counterpart, in accordance with the terms and conditions in the Project Agreement and annual workplans and budgets, facilitating the coordination of Project inputs and activities with programs at the central level of the MoH and between the central and regional levels, ensuring the efficient and appropriate use of counterpart-financed technical advisors, commodities and vehicles, ensuring that PL-480 funds programmed under the Project reached the regional levels in a timely manner and submitting annual detailed plans for the use of any Project funds (donation) provided directly to the MoH "

The UEP 2000 has been responsible in fulfilling their Project responsibilities PROJECT 2000 is their project and they are fully involved in almost all aspects of planning, managing, monitoring and evaluating it They have focused particularly on the PCMI and neglected, relatively, the Management and Financing Components of the Project (See Section 8)

The background to the UEP 2000's performance in PROJECT 2000, as described by all three partners, is that the MoH wanted USAID to fund the MoH directly - without an American institutional contractor USAID decided on an American institutional contractor, but reassured the MoH that they would play an important role in guiding and monitoring the Project and the IC Indeed, the Convenio between the USA and GOP, signed 9/30/93, states " As parties to the Project Agreement, the MoH and A I D are the primary implementers of PROJECT 2000 An U S Institutional Contractor, whom A I D will directly contract in consultation with the MoH, will assist them in this effort Major management decisions will be taken jointly by the MoH and A I D , with input from the Institutional Contractor " The Convenio further states " That Contractor will rely on overall policy and technical guidance from the MoH and the Agency for International Development " ⁹ The designated (MoH) Project Director shall have central coordination, monitoring and evaluation responsibilities for the Project, with specific regard to liaising with A I D /HPN in formulating overall Project policy and making major Project management decisions, providing guidance to the Institutional Contractor in Project Implementation " ¹⁰

Later, the Convenio states " The MoH will personally approve all Project documents that authorize procurement of services and will participate fully with A I D in guiding and monitoring the Project " ¹¹ The language of the contract between USAID and the IC differs slightly, but importantly, from that of the Convenio The contract states "The MoH Project Director will personally approve all contract documents that authorize procurement of services and will participate fully with A I D in guiding and monitoring the Project and the IC " ¹²

⁹ Page 2

¹⁰ page 10

¹¹ page 13

¹² Page 67

The UEP 2000 understands the language of the convenio and contract literally. They understand that they are authorized by this language to review every prospective purchase of services on the part of the IC regardless of the cost, and that their approval or denial thereof, of the prospective purchase should be based upon a serious review of the line items in that document. The UEP 2000 related that they are held accountable at audit time for their signatures approving the purchases and subcontracts of the IC. Audits performed by the Contraloria of Peru, last five to six months a year as each document is minutely examined. The UEP 2000 feels authorized and responsible for the cost-effectiveness of the IC and its subcontractors. They verbalized particular concern about the cost-effectiveness of the ESAN subcontract and about the salaries of individuals on that subcontract.

The IC points out they have a contract with USAID and are responsible through them to the US Congress. From their perspective, they are technically accountable to USAID and the UEP 2000, but financially accountable only to USAID that is both financially and programmatically accountable to the US Congress. They verbalize frustration at the delays the dual accountability results in, as well as frustration with the focus on process, rather than results, when the UEP 2000 assumes the role of financial supervisor (in contrast to technical counterpart that is welcomed). The technical relationship, which should be focused on results, becomes distorted by inquiries/concerns that arise from the role of financial supervisor.

The evaluation team knows of no other USAID project in which a USAID institutional contractor is held financially accountable to a host country government as well as to USAID for that contract between USAID and the contractor. Such a dual accountability is unfortunate, has been an impediment to smooth and timely implementation, and is inconsistent with management principles of clear delegation of authority, responsibility, and accountability. The team believes that an assessment of the cost-effectiveness of this USAID donation (versus loan) from the USA to the GOP is the responsibility of USAID, not the UEP 2000.

Recommendation

Language in the Contract between USAID and the IC for a Project extension should be revised so as to delete all language indicating that the MoH and its designated counterparts should approve "contract documents"

3.4 USAID

The SOW stated that the team should evaluate USAID performance regarding its overall Project monitoring responsibility, including the following: directly procuring the services of appropriate institutions to carry out the cost study and demand study, directly procuring the services of the IC, overseeing and guiding the IC activities, reviewing and approving workplans, and subcontracting activities, and modification proposals, providing feedback to the IC and MoH on Project implementation.

USAID has devoted great effort to PROJECT 2000, with both the IC and UEP 2000. USAID staff are committed and devoted to the Project and its partners. As will be noted below, Project monitoring and support is not easy, given the structure of relationships between USAID, the MoH, the UEP 2000 and the IC and its subcontractors - and the complexity of the Project itself.

The team notes, however, that on a number of occasions USAID has appeared slow to make decisions or bring issues to conclusion. For instance, the revised contract between USAID and the IC, which was reportedly approved by the MoH shortly before the team's arrival, had been in process for a year, in fact

some of the outputs in it are outdated at this point. The demand and cost studies, recommended in the Project Paper as to be completed prior to the Project with direct USAID funding and to provide input into the design of the national user fee system, were not completed until May 1996, sixteen months into the Project. The IC notes that the approval process took much longer than expected.

Strong support is needed from USAID on big issues. While the Project's evolution from that described in the Project Paper to the current status is understandable, it is unfortunate that USAID, as the one with ultimate responsibility, did not appear to maintain a "big picture" focus as the Project evolved - so that all parties would remain focused on objectives and outputs (results), even as they evolved. (See Section 2)

3.5 Structure

This Project has multiple parties involved with each of the three main "partners" (USAID, MoH, and IC). The multiplicity frequently leads to frustration. For instance, the first-line counterpart for the IC, as authorized by the MoH, is a special unit with contract staff, the UEP 2000, that reports to the Office of Financing, Investment and External Cooperation (of the MoH). Through the UEP 2000, the IC relates to the MoH departments who have line responsibility for maternal and child health programs at the central level, and at the regional level, the IC relates to the hospitals in collaboration with the UEP 2000, through the regional directors who report to the Office of the Vice Minister of the MoH. The IC, with responsibility for improving maternal/perinatal service quality and utilization and establishing sustainable systems in the programs of the MoH, has no direct relationship with the programs that have line responsibility in the MoH for maternal/perinatal health. Nor, according to the understanding between the IC and UEP 2000, is the IC's financial expert to have direct relationships with the various personnel and departments in the MoH that are charged with planning and financing health at the central level.

The UEP 2000, on the other hand, views the IC and its subcontracts as a series of layers and relates to ESAN, responsible for the acclaimed PCMI, through the IC and its subcontract with CARE. Add several levels and offices of USAID - streamlining the Project is not, from any partners' perspective.

In theory, the structure of PROJECT 2000 has advantages. PROJECT 2000's reporting to OFICE rather than line departments of the MoH might be understood as adding further technical resources and developing further commitment to the sustainability of PROJECT 2000 interventions.¹³ The fact of the matter is more difficult. The MoH line department directors the team interviewed stated they saw three parallel structures: the MoH programs, the UEP 2000 and the IC. Concern was expressed how the activities and processes would be transferred from the UEP/IC to the line program departments. The team did not sense that the MoH line program departments "own" PROJECT 2000, although they acknowledge and express appreciation for obvious improvements in PCMI-assisted hospitals.

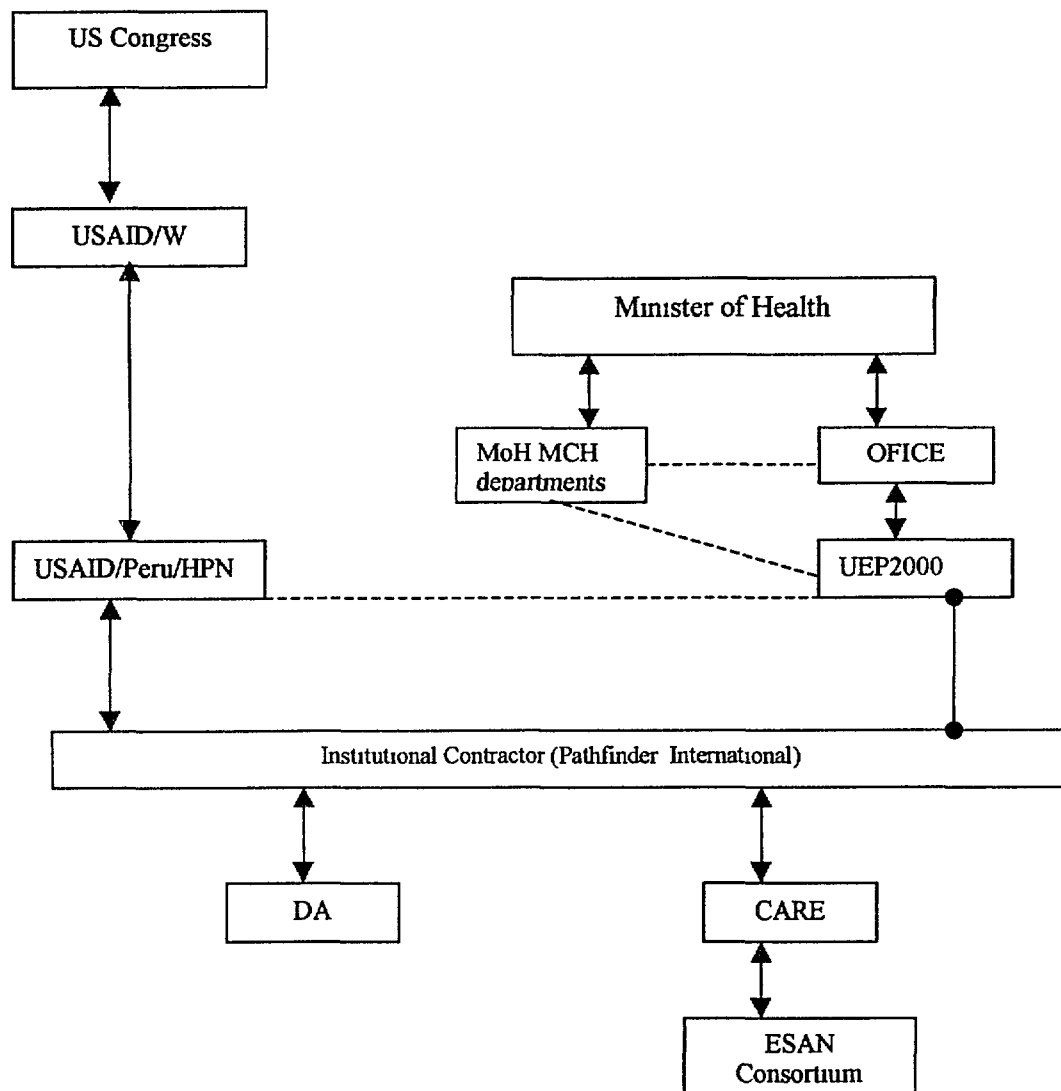
Despite this cumbersome structure, the Project has achieved important results, as are discussed in the pages that follow. The institutional arrangement frustrating to the UEP 2000 (PCMI being the responsibility of the ESAN Consortium) is the very one that has resulted in the innovative, successful and acclaimed PCMI. We do not believe it would be effective or efficient to change that arrangement at this point.

¹³ In addition to it being a wise structure in light of the weak internal controls noted in the MoH in 1993 as noted in Section 1.3.

- While the process may be frustrating, in the reengineered USAID, results are what count
- Any change in the structure of PCMI responsibility and accountability would lead to significant lost time and there is no time to be lost if PROJECT 2000 is to ensure institutional, financial and social sustainability of the PCMI before 2002

The following drawing illustrates the structure of PROJECT 2000 at the central level

Structure of Program Authority, Responsibility and Accountability in PROJECT 2000



Authority, responsibility and accountability =

Collaboration and Coordination to achieve common goals =

Technical accountability from IC to EUP,
Disputed financial accountability

"The MoH and USAID are the primary parties to PROJECT 2000. It is the role of the IC to implement the parts of the project that come under this contract under the technical guidance of the two signatories to the Project agreement. In all of these activities, USAID will consult extensively with the MoH. The MoH Project director will personally approve all Contract documents that authorize procurement of services and will participate fully with USAID in guiding and monitoring the Project and the IC." (Contract 527-0366-C-5049-00, 12/20/94)

3 6 Partnership

Although the Project's Convenio and Contract were written before USAID reengineering, USAID's understanding of partnership is relevant "Partners work directly with USAID to affect the circumstances of customers " "Customers are those individuals or groups that receive services or products from USAID, benefits from USAID programs or are affected by USAID actions Ultimate customers are those who are end users or beneficiaries of USAID's programs"¹⁴, presumably in PROJECT 2000 they are women and children needing/seeking health education and health services from the public sector

USAID and the UEP 2000 have viewed PROJECT 2000, a bilateral Project, as a partnership of two, with input from a third party who is held responsible and accountable for Project outputs The language of the Convenio and the contract, as well as the structure, reflects this state A contract extension may be the time to acknowledge that there is a third partner in this Project

Recommendations

The new contract should be worded to reflect USAID reengineering in which USAID and those who work directly with USAID to affect the circumstances of customers are considered partners

PROJECT 2000 should hold a facilitated workshop focused on results, using the PCMI problem-solving methodology to resolve conflicts, establish team work and increase professional collaboration among the three PROJECT 2000 partners

3 7 Coordination

Coordination occurs within PROJECT 2000 on many levels between the PROJECT 2000 parties and between this Project and other projects Particularly noteworthy at the regional and hospital levels was the constructive way staff pooled resources from regional authorities, various USAID Projects and other sources to fund facility upgrading as a consequence of their PCMI problem-solving

Coordination with REPROSALUD is particularly important as it works at the community level, coordination has not been very close nor does it appear that PROJECT 2000 has availed itself of REPROSALUD's findings and lessons learned at the community level USAID notes that in the communities where REPROSALUD works, women cite "white menses" (regla blanca) as their major health problem PROJECT 2000 does not appear to have picked up this finding or to be addressing it

Recommendation

At the central level, PROJECT 2000 should meet soon with REPROSALUD staff to plan how they might learn from REPROSALUD's community-level knowledge of women's concerns and needs and incorporate that experience, including that on white menses, into making PROJECT 2000 even more effective in meeting women's needs

¹⁴ IBID

4. STRENGTHENING CHILD AND MATERNAL HEALTH SERVICES - CLINICAL TRAINING PROGRAM/PCMI

PROJECT 2000's design envisioned a project to technically upgrade and extend the range of established child survival and maternal child health interventions (MCH) through a series of pilot model and interventions in clinical training, management and health financing. The Project's strategy was to improve the quality of MCH public services in health posts, health centers, and in surrounding hospitals through the development of a model inservice clinical skills training program, with a focus on the reduction of maternal and perinatal mortality. A series of baseline studies guides the implementation. While the bulk of training interventions were intended for the primary care and community levels, the Project also intends to strengthen hospital management of the obstetric, neonatal and pediatric emergencies referred from the community. An IE&C program component was to link and develop community support to increase demand and preventive use of services. Concomitant strengthening of management support systems and financing experiments are to enable the services expansion, access, coverage and overall sustainability of services.

4.1 Background and Changes in Program Design

The Project Paper (PP) targeted the need for skill-oriented and participatory clinical training that was not administratively separated from practical services delivery. It stipulated (1) a Lima-based model clinical training center for (2) training of multi-disciplinary training teams from regional hospitals, (3) regional hospital teams to develop other model hospital and local clinical training centers, and (4) model hospitals and training centers to provide clinical training to health personnel from surrounding hospitals, health centers and posts. Under the initial TA contract, this practice-based training model conceived in the PP was changed into a more standard cascade- multiplier training approach with MCH curricula, hierarchies of pilot training of trainers (TOT) courses and pilot training programs, etc. Numbers of training courses for various levels of practitioners and training content with output targets became major contract outputs.

During the second year of implementation major Project changes resulted in a superior and innovative training approach. Project experience and implementation findings coincided with unforeseen situational influences, discussed earlier, to influence substantial modifications to the PROJECT 2000 Project focus as to the training approach - and eventually followed by changes in TA contract outputs related to this component (see ANNEX 2 for revised Project Outputs). The changes in contract deliverables brought the training concept closer to the original Project Paper vision of practice-based inservice training. Other relevant changes in the size and number of Project regions and pilot establishments are discussed in Section 2.2.

PROJECT 2000 baseline studies of MCH service quality diagnosed serious deficiencies in the clinical content, the sequencing and completeness of basic clinical interventions. Studies of provider-client communications and interactions, client privacy, etc. revealed similarly dismal deficits in services delivery. Objective studies of health worker-client interactions validated the community perceptions of poor quality, unfriendly environment, and unacceptable personal treatment. Most aspects of critical MCH services were found wanting at primary care and hospital levels. PROJECT 2000 involvement with national specialty hospitals as clinical training centers, revealed clinical services as flawed and quality-stricken as those of the small rural facilities, with many of the maternal and perinatal deaths taking place in these hospitals on the second or third hospital day. This documented fragmentation and incompleteness of clinical interventions mandated major shifts in the clinical training approach from individuals to training service teams, and from curricula to on-the-job performance of standardized clinical practice. Relatedly, a 1997 National Training Commission workshop with representatives from the MoH, ODA, PAHO, the EEU, UNICEF, held to design a PROJECT 2000 clinical training strategy, concluded that the

standard training had failed to improve the quality and the manner of services provision. It proposed a Vision/Mission statement for a new human resources training approach to remedy the failures in services delivery. Spurred on by this challenge, PROJECT 2000 created the innovative "PCMI" (Programa de Capacitacion Materno Infantil), a model that uses a continuous quality improvement methodology (CQI) as the basis for a permanent clinic-based in-service training program.

PROJECT 2000 also was refocused. The Project Paper design envisioned clinical upgrading for the range of child survival interventions, adding emphasis on maternal and perinatal mortality. In contrast to the well-established child survival programs, maternal and perinatal health had made little progress, competing for limited GOP and international resources. In 1997 as GOP policies shifted to embrace maternal-perinatal mortality as top priorities, and perhaps serendipitously, limited PL-480 counterpart funds forced a narrowing of PROJECT 2000 interventions, placing priority on maternal and perinatal health. Important PROJECT 2000 support for this thrust was already in process - (1) the procurement of basic equipment, supplies and medicines for health establishments as an input to clinical improvement, (but which are not included in the terms of reference for this evaluation), and (2) the implementation of a Perinatal Information System (SIP) to monitor care. The SIP is a nationwide MoH information system, developed earlier by CLAP and PAHO, and has become a cornerstone of the PCMI model.

4.2 The PCMI Model "Clinical Training" Program

Implemented as a subcontract by the Escuela de Administracion de Negocios para Graduados (Consortio ESAN), Peru's foremost graduate Business School, the PCMI model draws heavily on international experiences with industrial psychology and performance-based management training models. PCMI comprises an innovative package of management improvement approaches to the public health services sector, using job performance as the training medium. Importantly, PCMI is foremost an ongoing (permanent) on-the-job "services improvement program" that builds staff capacities for quality improvements. Training is directly linked to ongoing performance measurement, rather than to knowledge gained. The PCMI model links five groups of institutional performance improvements (data-based practice, availability of basic institutional resources, teamwork, community linkage, standardized practice) with a form of institutional certification called "Qualification", providing the incentives and mechanisms for individual and collective quality improvements. This model invites, but stops short of, introducing a corresponding human resources development systems component. Included in the initial training of trainers was a core of professionals of the Regional Health Departments (DIRES) implementing and supervising the PCMI implementation. As the MoH is technically the implementer of PROJECT 2000 and PCMI, through the UEP 2000 2000, MoH policies and strategies for maternal-perinatal health and child survival shape the design and choices of MCH interventions.

4.2.1 Problem-Solving and Quality Improvement

PCMI training is in-service, on-the-job and practical, fortified by manuals, where suitable and available by interactive media or long-distance learning methods, where needed by professional exchange. Unlike established training approaches which tend to hold the trainee responsible for acquiring and selectively applying a large range of theoretical knowledge and skills as needed in work situations, the PCMI model tailors learning to the inservice requirements. PCMI trainees first develop skills in multi-disciplinary team problem solving in the workplace. Secondly, training is always practical, and tied to specific performance requirements in service provision, concentrating on the most common routines and tasks -e.g., prenatal examination, patient history-taking, etc. These are objectively evaluated against accepted performance standards, using team analysis, observation and self-evaluation to identify quality improvement and

learning needs. The training goal is change in practice and change in objectively verifiable behavior rather than improved knowledge and skills. PCMI "training" is in fact a continuous quality improvement (CQI) process, using team "apprenticeships" in a suitable service location. It is reminiscent of the historic "journeyman" traveling apprenticeship ("pasantia") to learn special skills in different workshops. PCMI uses the approach not only to increase the technical competencies of the professionals providing MCH services, but equally to obtain improvements in the organization and delivery of the critical MCH services, and to work with the community on the MCH problems. PCMI institutional improvement Projects, based on team analysis of the work situation and service problems, serve as the basis for establishing the inservice training program.

4.2.2 PCMI Concepts and Tools

- **Institutional self-evaluation and improvement plan** is the basis for quality improvements and also comprises an individualized training "curriculum" for every establishment and trainee. This plan begins with an inservice team analysis and reflection on their MCH services. Revised and re-worked, the institutional improvement plan guides problem-solving, creative use of resources, unites personnel into a common goal, and becomes the institution's training plan to strengthen the clinical abilities necessary for carrying out service team responsibilities.
- **Standardized clinical MCH practice** use of algorithms/protocols for MCH services delivery sets practice standards, teaches, helps to identify practice deviations and quality deficits.
- **Analytic techniques and operational studies of day-to-day MCH practice** used in every establishment to study service situations for problem solving - e.g., patient flow and work flow analyses, quality assessments using observational and behavioral analyses and other quantitative and qualitative analytical and study techniques.
- **Matrix organization for MCH service units** also uses in-service teams and committees to monitor, problem-solve, to plan, to lead and coordinate efforts on maternal mortality, quality improvement, pharmacy, IE&C and community, training, etc.
- **Functional MCH services networks** services focus includes a training hospital/center and its health centers and posts, the community health workers, as the conceptual units of MCH services improvement. This replaces the traditional institution focus.
- **Monitoring of MCH service statistics** - (SIP) **Perinatal Information System** the MoH's nationwide computerized database of maternity care case abstracts with over 60,000 pregnancy, delivery and birth records, provides institutional service analyses. It is used to analyze collective caseloads, high-risk outcomes and fatal events for problems solving. Near-future system refinements will permit analyses of case-management patterns, high-risk patient flow, and referral within the functional service network. Cross tabulations, calculations of rates, analysis with statistical parameters and significance are already possible. SIP provides input for teams and committees working on quality improvement and training.
- **Use of Clinically-based MCH Training Centers** reflects not only the inservice orientation, but also a strategic policy to increase institutional deliveries. Initially five specialist hospital centers were prepared to train a first group of "Trainers" from 12 regions, as the regional and local training facilitators for the 89 pilot Training Centers. The facilitator/trainers now impart the problem-solving methodology, assist the inservice quality improvement process, and assist related quality management. Specialist hospitals prepared "Tutors" in clinical services that plan and oversee specialized clinical apprenticeships in obstetric surgery, neonatal management, etc. as needed to upgrade skills. Two or three-week training

“pasantias”- literally “traveling apprenticeships”- at local qualified Health Training Centers (CC) or at local, regional or even national Hospital Training Centers (HC) is the key clinical training modality

- **Network Multiplier for local MCH services** local apprenticeship “pasantias locales” involve network health centers and posts in the MCH quality improvement training
- **Complementary MCH Learning Modalities** training in the own workplace and/or in other services sites uses a variety of algorithms/protocols, and are supplemented with self-instructional manuals or guides, partly from MoH vertical MCH and family planning programs Of particular promise are computerized interactive multi-media algorithms for training as for clinical management of maternal and child conditions These have excellent inter-active adult learning design, and are largely adapted from PAHO/WHO or CLAP by the MoH PCMI is currently also testing pilot long-distance-learning modalities using radio, e-mail, and mail in inaccessible geographic locations For facilities with critical staff shortage, a temporary personnel exchange is possible The apprenticeship facility substitutes a trained professional for the trainee on “pasantia” This modality maintains critical services coverage during training and additionally injects a trainer who can initiate or reinforce problem-solving in the recipient facility

4 2 3 “Qualification” and Re-qualification Incentive and Quality Control

PCMI “Qualification” currently denotes achievement of a basic standard of MCH services for the period of one year, which permits the qualified institution to function as a Training Center to assist and provide training to other establishments in its service network “Qualification” is the term used by PCMI to distinguish it from the MoH “Certification” of physical facilities, based largely on infrastructure criteria The PCMI introduction of “qualification” as a time-limited certification, to be repeated following objective re-evaluation against objective standards is perhaps the most advanced contribution piloted by PROJECT 2000 “Qualification” is also a big CQI incentive for performance improvement It is foreseeable that “Re-qualification” with increased quality performance criteria will be required to maintain the quality improvement incentive, and to limit the expected performance drop-off following peak accomplishment PROJECT 2000 has not yet developed necessary consensus among the Project partners on the criteria for re-qualification for each type of institution currently “qualified” at the basic level Similarly, neither has PROJECT 2000 found consensus on establishing a “vertical” quality enhancement plan for subsequent higher levels of qualification, nor has the institutional locus of “qualification” authority been resolved While responsibility for quality of health services delivery lies with the MoH, a role is seen for an independent external academic institution to validate the “Qualification” process, and eventually to link it to a national health sector human resources development and licensing plan

4 3 Summary Interim Findings and Observations

4 3 1 Implementation of Training Program

PROJECT 2000's 89 model Training centers have established a continuous quality improvement process in MCH and have passed the first level of a “qualification”, which has effectively installed a limited CQI quality improvement/training capacity in each of the 12 pilot Regional Departments Close to 100% of the targeted training establishments in the regions have now “qualified” at the basic level and have initiated further training, and are eagerly anticipating a re-qualification and possibly the chance also to qualify at a higher standard In the meantime, they are facilitating MCH quality improvement and training in the other

establishments in their service networks ESAN reports that as of March 15, 1999 a total of 350 local establishments in nine of the 12 Regions have now been involved in some local training through these "qualified" training hospitals and health centers The total number of network establishments in the 12 regions targeted by PCMI is about 2,500, suggesting that less than 20% of this Project target has been reached, with roughly 580 professional and technical staff (an average of two per facility) thus far with initial training to begin their respective institutional improvement plans

It is not possible to judge the extent to which the CQI training capacity is now fully installed in the region Nor is it possible from available information to judge how much reinforcement and cyclical re-training will be required to offset capacity losses due to personnel relocation, (estimated at 35-50% or more per year) An objective data-based analysis would be required to evaluate the actual capacity-building effects of PCMI and the attrition losses due to staff movement One general observation, however, can be made safely on the basis of the cursory review of PCMI implementation the capacity-building process in the "qualified" training institutions requires reinforcement, and monitoring

ESAN's original and ambitious model anticipated both the "horizontal" implementation of the basic quality improvement training throughout the Project regions, as well as experiments with "vertical" quality improvements with the establishment of higher quality standards and referral that would address clinical resolute capacity issues To date, re-qualification and vertical quality standards for different types of institutions have not been developed Though this innovative capacity-building model resonates of public services providers on the operational level, on the central level it appears to have unleashed a discouraging polemic on institutional "invention," ownership and control of the successful PCMI approach - and which tends to constrain efficient full development and piloting of the model

4 3 2 Horizontal Spread Within Institutions, Service Networks and Regions

As "qualified" training centers continue to pursue their own internal institutional MCH improvements, the approach is spreading within to other services Small establishments tend to be fully involved In larger, more differentiated facilities surgery, medicine, emergency services, pharmacy, and other departments ask to participate in PCMI The "horizontal" spread into the MCH service networks has already been noted MoH Central and Regional Offices (DIRES) housing a core of PCMI-trained professionals, are encouraging the rapid horizontal diffusion of the CQI training approach not only within each pilot departments, but equally outside of the Project This multiplier effect of PCMI training, which is marked by a proliferation of local institutional improvement projects as part of the local training, is creating a potentially powerful force for localized change Field impressions suggest, however, that the improvements are still fragile, that the more peripheral the establishments and their resources, the more support and reinforcement the establishments may require to institutionalize the new approach The thrust for horizontal extension has created a tension between a fuller "vertical" quality development and piloting of the model, with a rapid "horizontal" diffusion of the basic PCMI methodology Project implementers are cautioned not to over-extend the horizontal implementation momentum at the cost of reinforcement, support and nurturing for institutionalization and sustainability

4 3 3 Improvements in Facilities and Organization of Services

Importantly, the concept of "Qualification" has shown itself to be a strong team incentive to achieve a standard, and to inspire a spirit of competition among similar institutions Health services establishments in the PROJECT 2000 regions are enthusiastically embracing the challenge of quality improvement Field visits showed remarkable physical transformation of services sites - including client-friendly physical reorganization of services, made more accessible through a hostess-guide Walls are painted in warm, cheerful colors, and other improvements reflect deference to client and health worker preferences, and to community expectations Patient flow is generally reorganized to maximize integration of MCH services,

to reduce waiting time and improve patient flow, to ensure comprehensiveness of MCH services prenatal care, ARI, AEPI, immunizations, growth monitoring, diarrheal disease, nutrition, malaria, family planning, etc

Staff at facilities report expanded service sessions, clinic hours and general access. cursory review of services statistics in PCMI facilities working on institutional improvement do indicate fairly general increases in the use of MCH services, especially in institutional and professionally attended deliveries, and in prenatal and post-natal visits. As birthrates are declining, it is unclear whether these statistics reflect shifts in choice of institutions or providers toward PCMI services improvements, or previously unmet demand facilitated by improvements. Client and patient interviews validated observations about increased utilization due to perceptions of physically improved facilities, better staff attitudes (more favorable communications and interaction with patients). Staff reports of increased attendance and utilization, and staff self-reports of better motivation and attitude are commonplace. More definitive answers require systematic and comparative analysis of services statistics within and outside of the Project areas.

4.3.4 Improvements in Clinical Outcomes

The 89 hospital and health center Model Training Centers were chosen strategically to include those establishments which comprise the largest proportion of institutional births in their respective regions, so that quality improvements in maternity case management would most directly affect substantial numbers of maternity and prenatal cases. Though PROJECT 2000 is theoretically re-focused on maternal and perinatal mortality, PCMI problem-solving and CQI for maternal and perinatal health on the operational level are totally integrated with related MoH vertical programs (ARI, DDC, Growth Monitoring, EPI, Sick Child Initiative, Nutrition Counseling, Basic Health for All, Maternal Health, Family Planning, TB, community and IEC, other programs). PCMI is the mechanism for integration- partly because of the attractiveness of its approach, and partly because it is the dominant force which has captured the health workers' motivation. While PCMI was developing, parallel training and supervision continued under vertical MoH programs, but now both training and supervision - for better or worse - are increasingly integrated into "PCMI" scheduling. On the positive side, this integration has served to make available considerable additional resources from a variety of programs for PCMI initiatives. As a result, improvements in client orientation, patient flow, comprehensiveness and completeness of MCH services, etc., have increased the number of consultations for all services.

Staff describe problem-focused and patient-centered work goals, which are manifest in the records of maternal health problem analyses (for example, quality and maternal mortality committee reports, Libro de Actas). Committee reports on problem solving indicate much increased staff attention to detail, completeness and integration of physical examination, completeness and correctness of pregnancy histories, counseling and instruction to patients, and much increased staff awareness of the importance of adhering to standards of practice. Random reviews of SIP facility reports, over a period of 12 to 15 months, do suggest improving management of MCH conditions - in terms of completeness and correctness of patient history, examinations, adherence of practice to protocols (laboratory tests, immunization, patient education, etc.), as well as much improved SIP entries, and analyses of SIP data. ESAN's baseline and midterm surveys (1996-97, and 1998) demonstrated by objective measures noteworthy improvement in the adherence to clinical protocols/algorithms for hospitalized children. This suggests that PCMI probably can be shown to have affected directly a number of general clinical MCH outcomes, through the integration of child survival interventions. Integration also may be a strong force for institutional sustainability. On the other hand, the integration of services possibly dilutes a potentially stronger PCMI effect on maternal and perinatal care. Yet, at the same time, MCH services are becoming more complete, most establishments are mapping catchment area pregnancies, "radar de gestantes", to

track and follow-up at home high-risk pregnant women. More high-risk women are being identified, and through problem-solving, the proportion of professionally attended deliveries are increasing. Similar progress is being made in perinatal care: neonatology skills are now integrated into the delivery room and maternity ward. Neonatal management and resuscitation follow protocols, many hospitals now are equipped and trained to keep alive premature and low birth weight infants.

Most facilities show SIP decreases in the number of maternal deaths and seeming increases in the numbers of high-risk pregnancies attended. While this may be due to improved reporting and classification of maternal deaths, there is strong evidence of improved risk identification, improved management of high risk cases, and possibly reduced case fatality ratios with the use of algorithms. Similarly, cursory SIP reviews also suggest decreasing percent of low birthweight infants lost in selected PCMI hospitals over 12-18 months. Installation of improved SIP analytic software will soon facilitate thorough analyses of PCMI facilities and their services networks. It is hoped that an effective PCMI Supervision System will then focus on the patient and case-management outcome patterns, and will use the information for continuing cycles of quality improvement and reinforcement.

4.3.5 Observations on Training Approach

Field observations, interviews and ESAN surveys all indicate that the PCMI training approach does facilitate effective adult learning, attitude and behavior change as measured in performance improvements. Acquiring a problem-solving orientation, problem-solving and planning skills, are the major steps that also enable the adult learners to master a self-improvement process - which bring with it changes in attitude and behavior. These are mediated by team process. The evident pride of PCMI health professionals and workers in the collective accomplishments - physical improvements to facilities, the improvements in the organization and content of services, and the increase in patient utilization of services, the "Qualification", etc. is unmistakable. PCMI's approach of team-based work and problem-solving, appears to enable individuals to "act" within the security and support of the team structure, while enabling them to develop an individual sense of mastery. Discussions with health functionaries suggests that the PCMI team-approach, not unlike membership on a sports team, generates a number of synergistic effects, including "valuing" of the collective goal, of team members, etc., which in turn may encourage and "mold" individual attitudes and behavior changes. PCMI's approach appears to be encouraging team initiative, building technical capacities, and appears to be developing management capacities on the part of team and work leaders. It is reportedly changing the attitudes and behavior of health workers toward clients as well as toward their own work. Similarly, there are indications that the approach also is empowering female professional service providers and health workers, who carry out much of the "hands-on" problem solving teamwork.

As a word of caution, given the enthusiasm of services providers for the CQI approach and its rewards, Project implementers should be careful not to overlook the fragility of the gains and not to underestimate the supervision and reinforcement required to fully institutionalize the program. Given the pilot nature of the PCMI program, implementers are encouraged to make use of PROJECT 2000 to explore increased efficiencies in training and institutionalization of the PCMI approach.

4.4 SOW Questions

1. Is the PCMI training model improving the quality of maternal/child health services in the proposed period? Would these changes contribute to reduce maternal and child perinatal mortality?

Yes, as discussed above, the PCMI training model is already improving the quality of maternal/child health services, and may be expected to increasingly do so as the Project is more fully implemented in the

proposed period. With respect to the contribution of these changes to the reduction of maternal and perinatal mortality, the answer is complex. The current changes seen are making services more accessible and acceptable to pregnant women with geographic access to these services points. As a result, more women will be screened for high-risk conditions. Increased utilization of more vigilant and resolute prenatal care, with improvements in case management of problem cases is certain to affect case fatality outcomes, and will reduce both maternal and perinatal mortality to some extent. Provided that the 89 model training hospitals and centers, which together deliver close to 90% of all institutional births in their regions, are able to augment and sustain their quality improvements, they will have a significant positive effect on the mortality rates in those institutions.

To make inroads into the most intransigent maternity problems - in areas with poor access to acceptable prenatal and supervised delivery care, frequently with no access to effective emergency care - is still a major challenge and continues to be the chief source of mortality risks. The PCMI model must still demonstrate community leadership, network referral mechanisms and clinical response capabilities that can resolve the pregnancy problems, obstetric and neonatal emergencies that the community brings to attention. The question, thus, is not "whether" the PCMI changes will contribute to the reduction of maternal and perinatal mortality, but rather, "how much," "provided that" and "with what investment."

Once mortality among the users of services has decreased, the "easy" part will have been "scooped off." Each additional increment of mortality reduction will require more effort and resources. To substantively reduce mortality, three additional aspects of the PCMI Model must be fully developed and demonstrated: (a) a strong community component with pregnancy/delivery vigilance that reaches out also from even the most distant primary care points of each network, (b) a network referral system with emergency provisions, and (c) clinical capacities to handle the referred obstetric cases and the emergencies brought directly by the communities. Perhaps one of the most important PCMI demonstrations - and challenges - of the CQI approach will be to make emergency obstetric care effective as well as accessible.

2. Is the Perinatal Information System (SIP) being utilized to detect risks and prevent complications in pregnancies and deliveries?

The SIP itself is not intended to be utilized for clinical use. Rather, it is a computerized record of how clinical practice is conducted to detect and prevent risks in pregnancies and deliveries. The current SIP system can give service "profiles" of practices, case management and patient outcome summaries for any establishment providing prenatal care, deliveries, postpartum and family planning care. Future SIP versions will permit analysis of practice within service networks. SIP is being utilized in all PCMI-facilities as a basis for analyzing practice for quality improvement. It is a powerful information system with great potential analytic capability to monitor not only the implementation of PCMI quality improvements, but also to compare with non-PCMI institutions, and to monitor maternal and perinatal case clinical services and case outcomes on all levels of care, service and geographic units, and nationally. Recommended SIP analyses are included in the Report's Recommendations Section under "Operational Investigations and Studies."

4.5 Summary Findings and Recommendations

- Implementation of the first phase of the PCMI Model in the 89 current health establishments is generally proceeding successfully at the basic qualification level, and is showing evidence of improving quality of MCH services and increasing demand. The PCMI is now at a critical juncture for determining program thrust for the next program pilot phase - "vertical" increases in levels of quality versus "horizontal" spread of minimal quality improvements to the 2,500 establishments
- Use of algorithms/protocols and SIP-based critical review of clinical practice are now variably well established in PCMI. Actions to assure the quality of protocols are now a priority. Quality and control of SIP data is good, but there are lingering problems with software skills, technical support, competition with other MoH programs for computer use. Peripheral establishments may require more assistance and reinforcement
- The motivational force of "qualification" for CQI has been demonstrated, but the behavioral changes and improvements are still fragile and require continuous reinforcement and nurturing, with specific goals for MCH service improvements
- PCMI is integrating vertical MCH programs operationally, with intramural spread to other departments - medicine, surgery, pharmacy, etc. While this contributes to institutional sustainability, it is important to maintain a focus on maternal and perinatal mortality
- PCMI's contribution to Peru is the piloting of a model combining innovative approaches to human resources development and quality improvement for MCH services. It is important to maximize the potential impact of USAID's contribution by demonstrating the model as fully as possible with the remaining components

Recommendations

- Complete and consolidate the implementation of basic qualification and community activities in current 89 health establishments. Balance "horizontal" implementation in each of the 89 establishments with targeted "vertical" quality increase (i.e., using SIP-analysis)
- Design PCMI pilot vertical quality improvements, differentiated "Re-qualification" criteria and re-qualify a subsample of currently qualified establishments. Test additional motivational goals, include recognition awards, prizes and competitions
- Complete design of community component and demand creation, linked to clinical capacities. Rapidly advance the development of clinical resolutive capacities, pilot critical referral systems and community problem-solving around emergencies
- Consolidate and reinforce use of protocols and SIP, especially in the peripheral service networks. Use SIP analysis, PCMI service improvements and results as motivational tools. Disseminate. Investigate SIP computer access and problem-solve
- Plan, test and complete additional steps in pilot training/education and quality improvement approaches - self instruction, long-distance education, possibly pilot the introduction of PCMI approaches into basic professional education and training curricula, internships and residencies

- **In next Project phase document, evaluate and disseminate PCMI experiences and gains initiate systematic analyses with SIP and HIS service statistics Develop methodologies for simple investigations, analyses, case studies, etc for documentation and as motivational tools Suggested examples**
 - **Analyses of HIS service statistics** compare analyses of regional trends, PCMI and non -PCMI facilities to explore and explain MCH utilization patterns
 - **SIP analyses** explore and compare PCMI use and quality of SIP data
 - analyze, chart, and compare SIP quality indicators for PCMI and similar non-PCMI institutions
 - compare PCMI composite and disaggregated trends in rare event outcomes
 - trend analyses of case outcomes, with ANALYSIS explore case origin, referrals
 - analyses of PCMI rural hospitals data quality, case origin and utilization patterns, case management patterns, improvements, service network analyses when possible
 - **Case studies** of team problem-solving and resulting client-oriented improvements in physical facilities, service organization, teamwork, with community, etc (These can be prepared by HC and CC service teams)
 - Case studies of specific clinical quality improvements
 - Case/Panel studies of management development through PCMI in selected facilities
 - Case/Panel studies of professional/personal empowerment through PCMI of women professionals, health workers in selected service teams

5 INFORMATION, EDUCATION AND COMMUNICATION (IEC)

5.1 A Late Start

In December 1993, an agreement was signed between MINSA and USAID resulting in PROJECT 2000. In December 1994, after the appropriate negotiations, USAID and the institutional contractor, Pathfinder International, signed an implementation agreement for the project that included the participation of Development Associates Inc (DA) and CARE/Peru as subcontractors.

PROJECT 2000 began its activities in February 1995, and after 18 months, by August/September 1996, technical assistance was provided for the IEC and Community Training (CT) components. In that year, 1996, CARE incorporated EAT, a consultant specialized in CT. JHU/CCP signed a sub-agreement with Pathfinder to develop IEC activities, and ESAN, in a consortium with the University of San Marcos and Manuela Ramos, signed an agreement with CARE to handle PCMI and CT.

The long delay in the start-up of IEC and CT activities was partly due to the administrative procedures for dealing with subcontractors followed by Pathfinder and USAID. Start-up of the CT package was stretched out unnecessarily given CARE's extensive experience in the country. On the one hand, Pathfinder and CARE did not incorporate the CT specialist into EAT at the beginning of the Project. Neither did they set about the task of immediately starting to implement the CT component. Pathfinder requested that CARE sign an agreement with ESAN in order that Manuela Ramos could take over the CT activities.

Recommendations

From the beginning of the extension, IEC and CT activities should start immediately and continue without restriction for the life of the Project. All administrative measures should be undertaken on a timely basis in 1999 so that there will be no delay in starting the extension activities.

In order to ensure the implementation of IEC and CT activities, a written agreement is needed with DIRES regarding the different sectors to establish priorities for cooperation in promptly carrying out IEC and CT activities. Also, a detailed implementation plan should be elaborated immediately for the 24 months from January 2000 to December 2001.

5.2 Insufficient Technical Assistance

The technical proposal, presented to USAID by Pathfinder during the selection process of the PROJECT 2000 contractor, included significant IEC and CT components. During the negotiations for the signing of the contract between Pathfinder and USAID, the budget was adjusted and the impact of that modification was evidenced in the IEC component.

After the negotiations and development of a new IEC budget (US\$ 1,024,000), the contract between USAID and Pathfinder was signed. The revised design of the objectives and planning of the IEC and CT components did not provide adequate technical assistance to allow for the redesign of the IEC and CT components. If the IEC and CT components had been re-designed, precise terms of reference could have been given for the sub-contractors. As a result, the IEC and CT components, neither in theory nor in practice, were appropriately articulated in the PCMI context.

It is evident that, technically, redesign of the IEC and CT components was needed, not only for the aforementioned reason, but also because of the variables that MoH indicated in this regard with its intervention in other projects such as PSNB/WB.

Now, after five years, PROJECT 2000 with PCMI, IEC, and CT has some successes to demonstrate and new challenges to confront under the extension. IEC and CT have a clear area of involvement, useful tools and an agenda to fulfill, as well as lessons learned and concrete requests from local IEC groups to meet.

Recommendations

Focusing exclusively on PCMI's objectives and indicators, which need to be revised and agreed upon for the extension period, new objectives and indicators must be designed with absolute clarity as to what IEC and CT's involvement should accomplish in the 24 months of the extension.

Taking into account the following aspects which circumscribe the extension:

- The central recommendation of this evaluation, to consolidate that which has already been achieved by the PCMI
- The existence of various cultural barriers in the community in each location
- The size and location of the target group covered by the HC and CC which are organized in networks and micro networks in the PCMI
- The training already carried out with health-care providers, promoters and midwives
- The need to optimize USAID resources and the limited time available for IEC and CT activities during the extension

- It is recommended that the IEC and CT components be integrated into a single "IEC/CT" component

It is recommended that for the project's extension period, the "IEC/CT" component be designed as a component concentrating resources and efforts -- IEC methods and CT strategies for activities in the community with the participation of health-care providers and midwives

It is suggested that MoH and USAID include outside technical assistance in the selection of objectives and indicators, in designing and planning of the "IEC/CT" component for the second and/or third trimester of 1999, and that they work with the present CARE/IEC team that is putting together EAT, as well as with the units and/or those responsible IEC individuals in DIRES, HC and CC in each location, so that the objectives, indicators, terms of reference, budgets, etc , may be realistically framed under the extension amendments' Scope of Work to include data helpful to the contractor and eventual subcontractors for focusing their activities and sharpening their output

During the project extension the "IEC/CT" component must be carried out by two full-time IEC specialists experienced in community activities at the central level of EAT Thus, it is recommended that the CARE IEC consultants, who make up part of the EAT team, have their term in the project extended and that the CARE subcontractor provide his assistance and technical support to these consultants

5 3 Formative Studies

Between November 1995, and August 1998, EAT with the assistance of various local consultants (Drs Codina and Peña, Lic Guardia, Naccarato, Universidad Catolica, Universidad San Marcos and Centro Flor Tristan) carried out various studies linked to formative research seeking to obtain recent data on the larger health topics covered by the Project The methodology, the implementation, and the value of these results are relevant to both Maternal Mortality Case Studies and Traditional Delivery Techniques and Care of the Newborn

Recommendation

The results of this research should be appropriately edited, published, and disseminated in the different areas where the data were collected

5 4 The Subcontracts

At the local level EAT carried out important activities in the different areas for which, in the last four months of 1996, a CARE consultant specializing in community relations was added to the team, and JHU/CCP was sub-contracted for IEC and ESAN/Manuela Ramos for community training

With the exception of the rapid needs assessment (RNAS), the JHU/CCP sub-contract was carried out in a timely manner following scope of work at the local level

- Designing training models and manuals
- Training health personnel in interpersonal communication
- Educating IEC personnel in IEC strategic planning
- Monitoring and advice

The RNAS was carried out with the participation of previously trained regional teams. What this participative methodology achieved were credible results that allowed the local participants to discover a context which enriched their daily tasks. The results, in many cases, served as working data.

The designed modules and training manuals are thematically appropriate, but could have, perhaps, incorporated selected RNAS results from each sphere to individualize the models and examples, thereby enriching participation at the local level. Regarding the production process, the manuals were not validated by the users prior to publication.

EAT has closely supervised the implementation of the JHU/CCP sub-contract, in particular the training efforts with health-care providers and local IEC teams who, in turn, have applied what was learned and, without a doubt, have collaborated in reducing some cultural communication barriers. PCMI has been strengthened and enriched by the achievements of these workshops.

In brief, the benefits of the PROJECT 2000 intervention through the IEC component is positive and clearly demonstrated on two levels:

- On one level, the health-care providers group improved provider-client communication lowering community barriers.
- On another level, and also for the group of health-care providers, there was new recognition of IEC among DIRES, HC, and CC, forming multidisciplinary IEC groups and naming leaders of IEC in various establishments. This allowed articulation of IEC plans in each location and incorporation of a methodological concept that some regions have been able to develop appropriately.

In 1998, in each location IEC plans were made, the practical structure allowed the proposed activities to be undertaken. However, it is noted that these plans did not include a section for incorporating the main findings of studies that may have existed in each location, and likewise, neither were community aspects included which PCMI considered in its activities. The 1999 plans showed better detail.

The benefit at the community level cannot be measured yet since the subcontractor (ESAN/Manuela Ramos) recently ended training involvement for providers and midwives. Nonetheless, there were many providers and midwives trained who now represent a strong and appreciated community resource.

Recommendations

In the last trimester of 1999, already trained local teams -- with outside technical assistance and using observation techniques -- should, in each location, determine the need to improve providers' skills in interpersonal communications with clients.

Feedback should be obtained through in-depth interviews with health providers who have practiced the provider-user technique in order to correct training manuals.

Review the cultural barriers still existing in each location, so that during the extension, those more likely to be resolved may be given provider/client and IEC/CT attention.

Using existing information, it is recommended that the project work with community groups and IEC advisors to identify whether there are training needs to complement methodology and/or skills in order to achieve adequate impact-evaluation levels for IEC/CT by mid-year 2000.

The EAT IEC consultants must support and track the process of technology transfer in those areas where it is decided to replicate the "IEC/CT" in the PCMI influence network and micro-network, thereby promoting sustainability

The IEC/CT plans should be designed for 24 months and incorporate a section on research findings, clear identification of the cultural barriers that have been given priority for behavior changes need to be suggested to health-care providers and to the target group of the community. This should permit design of the best involvement strategy for rural zones and allow for the successful delivery of messages with existing resources within the extension period

All providers and midwives in the different locations, who have been trained, should work with IEC/CT educational materials that are most appropriate for urban-rural and rural settings

5.5 Excessive Flexibility

An "excessive flexibility" is noted in the delivery of products for the IEC and CT components in the different PROJECT 2000 locations. For example, in terms of the JHU/CCP and ESAN sub-contracts, several of the products delivered were not expected, or as in the case of the "generic materials" were made in the EAT. The products delivered to the Project are agreements by parties and/or apply to contractual amplifications negotiated in each sub-contract in order to add or substitute products

In the case of Pathfinder, the educational brochure has not yet been circulated. They have distributed periodical publications as a brochure, but the contents are general and newsy -- it summarizes activities and renders accounts of achievements. It is hoped that ESAN will edit the educational brochure and that it be distributed in the health establishments

On the other hand, a variety of IEC materials, produced by the regions with MoH resources, are appreciable in the different project locations, demonstrating good initiatives which overcome the local technical limitations and which, according to those who brought it about, followed the learned methodology. On the whole, these products are of good quality in the choice of communication objectives and in content delivery

Recommendations

The extension amendment SOW should be precise as to the products requested of the contractor and sub-contractors

The creation, design and validation of the materials production for the "IEC/CT" component should be done by the IEC groups or teams in each project location, and the production should be in response to each plan's strategy

In order to guarantee that the central and local production of materials be carried out without delays, it is recommended that a "production of materials Protocol" be developed, with a list of steps to be taken and timeframes to work within, in which all those involved should be considered and in which the critical route be identified. This protocol should be known and approved by all those who participate in the process

In order to ensure that the production of messages in each location achieves specific "IEC/CT" plan objectives, it is recommended that the "Thematic Matrix" be designed and included in the

plans of the 24 month extension as a basic tool for producing messages The model should consider the following variables

- MINSA standards for the subject
- Research results
- Cultural barrier
- Target group
- Subject content
- Channel to be used
- Period for the delivery of contents to the community

Each location has qualitative, quantitative, and local KAP research results, its own cultural barriers to resolve and each its own nuances Thus, the production and distribution of "generic materials" is not recommended This type of material, proper to the "umbrella campaign" strategy, is not applicable to the PCMI and does not fit in the "IEC/CT" strategy

All products delivered to the project should have the validation of the target group who will use the product The validation should have an understanding and total acceptance of the product In the case of the manuals to be validated, in-depth interviews should be taken advantage of in order to make the necessary changes This is an opportunity to provide adapted and specific manuals, following experimentation by the health providers of the provider-user technique that has been developed

The printed material produced at the local level should have a footnote indicating the project name and number and the production date All elements that do not have anything to do with the subject should be minimized or eliminated

In order to appropriately collaborate with the transfer of technology at the central and local levels, the EAT IEC/CT component should standardize and systematize everything that has been produced and is to be produced for the project extension period At the central level, the transfer should take place with two offices, the Maternal and Child Health and the MoH Social Communication office At the local level, this transfer should occur with the IEC groups and/or teams of each DIRES covered by the project

The systemization should include new formats as Rapid Reference Guides and/or Tool Manual for determined "IEC/CT" processes In this context, the educational brochure should be considered for production at the end of the year 2000 and be a part of the systemization

5.6 Local Need for EAT TA

The current monitoring activities being carried out by UEP 2000 2000 and EAT have detected that the local IEC groups have reached different levels of skills This is due to the fact that some of the groups have been just recently created, and also to personnel rotation With regard to the promoters and midwives, they are carrying out their work in the community in coordination with the HC and CC The different IEC groups and leaders constantly ask EAT for diverse technical assistance support

Recommendation

It is necessary to appropriately organize the technical assistance for the extension period in accordance with the present needs and requirements of the local IEC groups It is recommended

that the following structure and a certain scope should be clearly stated in the extension terms of reference

- The two CARE consultants in EAT positions should focus their activities on the supervision of outside technical assistance, monitoring the local 24 month plans, and assessing the impact in IEC/CT. This general scope allows recommending that 70% of the consultants' time be spent in the areas providing the support of the local IEC/CT groups
- **Outside technical assistance** is recommended to strengthen the providers' provider-user techniques, achieve uniformity in the level of methodology of the local IEC groups, train in IEC/CT impact assessment skills, locally support the provision of instruments to the promoters and midwives, and standardize some instruments for systematization. A period of 12 months of outside technical assistance would allow this scope to be met

Recommendations

It is a requirement that all the IEC groups from the different locations achieve an appropriate level in order to receive IEC/CT impact assessment training

As a principal means of reaching the community, the members of the local IEC groups should interact with the health-care providers and midwives in extracurricular activities. Thus, the local IEC plans should include the providers and midwives in a sphere of activities in the community

5.7 Supply and Demand

PCMI as a whole has brought about important changes in the supply of services. In brief, it is foreseen that users will state that the impact has been positive. This would lead to the supposition that the establishments are ready to embark on Public Marketing campaigns in, or to promote supply and mobilize demand.

Recommendations

During the PROJECT 2000 extension and period of technical assistance in IEC/CT, the focus of priority should be on consolidating what has already been achieved, completing the technical transference of the IEC/CT method to the different locations. During this extension period, it should be assured that the IEC/CT activities meet their objective which lead demand to mobilize reasonably well, one has to assess whether this single intervention can saturate the Project's supply of HC and CC.

The IEC/CT leaders at the central and local levels should be involved with the organizers and promoters of the next MATERNAL AND CHILD HEALTH INSURANCE, whose media campaign at the national level is expected to be quite frequent. Launching this campaign will, no doubt, impact the mobilization of demand in the Project areas, thus making unnecessary the broadening of IEC/CT activities through the social marketing of services. The supply will be covered with all these variables and events foreseen in the extension.

However, understanding that there will be many opportunities in which the local IEC teams will be gathered for various types of workshops, it is recommended that, when the uniformity in the level of IEC methodology has been reached, the IEC teams be informed about social marketing and its opportunities in the community.

6 SUPPORT SYSTEMS

The IC was responsible for four systems to support the child and maternal health services

6.1 Health Information System (HIS)

The IC was to undertake an "evaluation of the presently functioning Health Information System (HIS)" and, according to one part of the revised draft contract, upgrade it, another section of that draft contract contains no mention of upgrading the system. The contract for the evaluation was competed and won by Calmet Data S A who undertook the evaluation from August 1997 to April 1998. Calmet published its findings, conclusions and recommendations in a detailed multi-volume report. Looking at the national HIS and at the information systems of key national maternal/child health programs including the Maternal/Perinatal, CEDA, CIRA, Growth and Development, Family Planning, Women and Development, the contractor concluded that the national information system had grave deficiencies, the degree of which varied from region to region. The data is not timely, often is not valid, and is not used for decisions. Staffs are not trained in information technology, there is constant rotation and obsolete equipment.

The assessment concluded that information on maternal mortality was particularly poor and personnel have no faith in the data.

- Underregistration of maternal death
- Different formats for registration of maternal deaths which are filled out incompletely and incorrectly
- Incorrect diagnosis of death¹⁵
- Workers don't recognize value of information on maternal mortality

Calmet made a series of recommendations for a thorough updating and overhauling the systems, including one of integrating the national HIS and the systems of the various programs (such as Maternal/Perinatal and CRED). There were recommendations for immediate change, another for short-term, medium term and long-term improvement. Significantly, structural MoH change was a key part of the longer-term recommendations. There is no apparent follow-up to this evaluation. To the dissatisfaction of the UEP 2000, the IC is not planning further work on the national HIS or national programs, nor is there any apparent response from the MoH.

The team concludes that the IC is wise to stop at this point. Upgrading and overhauling the national and information systems of the various programs is a very major undertaking with political and structural ramifications, it is a full Project in itself to which the Ministry would have to be fully committed over a number of years. Moreover, to be effective and efficient, the technical assistance team should work directly with the MoH line departments involved, rather than through a counterpart Project office as in PROJECT 2000.

¹⁵ Note, even among some of the physicians in the PCMI hospitals the team visited, there is a lack of clarity about maternal death. Two physicians in two different hospitals included the deaths of pregnant women who had died as a result of spousal physical violence in their maternal death tally. The EAT member accompanying the team corrected the definition.

6.2 An Information System Component, Integrated with the Presently Functioning HIS System, that Tracks PROJECT 2000's Indicators within the Priority Area

The draft revised contract lists "an information system component, integrated with the presently functioning HIS system, that tracks PROJECT 2000's indicators within the priority area" as an output. PROJECT 2000 has developed the excellent SIP, described in Section X above. SIP is not integrated with the HIS, nor given the state of the HIS, would such integration be a good investment. The SIP is currently used to analyze collective caseload and high-risk outcomes and fatal events. In the future with system refinement, it will be used to analyze case-management patterns and high-risk patient flow and referral within the functional service network. It does not track PROJECT 2000 indicators.

As indicated above in Section 2, PROJECT 2000 needs to, formally and explicitly, reformulate the conceptual framework of the current Project Indicators. Indicators are simply measures that help a project/program compare expected results with actual results on a periodic basis - results at the outcome, output and process level. More importantly, PROJECT 2000 needs to come to consensus on the desired and realistic results to be achieved at the end of the extended Project.

Recommendation

USAID, the UEP 2000 and IC should work together, through a facilitated workshop¹⁶, to come to consensus on the desired and realistic results to be achieved at the end of the extended Project. They should explicitly

- **Redefine the purpose and scope of the Project**
- **Redefine population-based indicators based upon that scope**
- **Set targets based upon 1996 DHS data**
- **Revise the Project objectives in light of current realities and possibilities, and establish indicators**
- **Integrated PCMI results with results in finance and management (related to institutionalization and sustainability)**
- **Define, if possible and appropriate, service utilization outputs in PCMI-related facilities, and establish indicators**
- **Define service outputs in PCMI-related facilities and establish indicators**
- **Come to consensus on functional outputs and the process for achieving them**

6.3 A Decentralized Monitoring and Supervisory System in the Priority Areas

The draft revised contract indicates the IC's work would include design and development of the system, training in the system for MoH personnel and resources for its implementation. The IC has not accomplished this output, nor is such a professional system a likely and feasible output. A supervision system in most institutions would include, minimally, the following components: job descriptions, performance objectives, performance appraisal, and supervisory protocols. It would be based upon an organizational chart with clear lines of authority and supervisory levels. Job descriptions for personnel in any one department would be complementary so that, together, employees completed the functions of that department. Departments together would achieve the goals/objectives of the institution. Whether

¹⁶ Project 2000 should ask Pathfinder to recruit a two-person team to lead the workshop: one person should focus on problem-solving and conflict resolution. The other would be a health resource person who could assist with the conceptual framework, particularly in terms of population and program-based indicators.

employees worked individually or in teams, together they would resolve problems and achieve the goals of their departments and the hospital

The IC has developed a supervisory philosophy, approach and tools for PROJECT 2000 staff to supervise PCMI-assisted maternal/child health departments in PCMI-assisted hospitals. It is an enabling, coaching, supportive CQI approach that promotes motivation, problem-solving and self-supervision. The Project has written and shared several conceptual papers on the approach, trained staff during "pasantias" and attempts to model the approach during supervision and training. The approach shows such signs of informally spreading beyond MCH departments in PCMI-assisted hospitals, however, it is not an institution-wide approach in any PCMI-hospital.

Staff in PCMI-assisted MCH departments, in theory and often in fact, are "supervised" by at least four and sometimes five different external (to the hospital) groups with slightly different foci:

- ESAN supervises for certification
- EAT and regional supervisors supervise for technical support and technical coaching
- UEP 2000 supervises for technical support and technical coaching (counterpart to EAT) and for adherence to MoH policies and procedures
- Regional Directors and their staff supervise, giving moral, technical and logistics support and guidance within regional norms
- UTES staff supervise from a political and normative perspective

In theory, at least, the first four groups (external to the hospital) are using the PROJECT 2000 enabling team approach. Ideally, however, a hospital would have a system of supervision internal to the hospital, beginning at the top and flowing down from there - not in the negative, punitive sense many people have of a hierarchical structure that controls rather than enables, but in the positive sense of goals being set at the top and resources mobilized so to achieve them. It is highly unlikely that the IC would be able to design, implement and evaluate an institution-wide supervision system for any of the PCMI-assisted hospitals in PROJECT 2000. What it can - and is doing - is working on processes to supervise PCMI activities in PCMI-assisted facilities, given the current realities of four external groups supervising those activities.

Recommendation

PROJECT 2000 should continue promoting the PCMI supervision approach developed and shared to date. It should continue working on processes to enable complementary and mutually reinforcing supervision of PCMI-assisted activities by the external groups listed above. To promote institutional sustainability, a plan for gradually transferring full responsibility to the DIRES and local hospitals should be developed. (See Section 9)

6.4 Drug Supply System

The IC was to "supply technical assistance to the Dirección General de Medicamentos y Drogas (Directorate of Drugs and Medicines of Peru, DIGEMID) on the analysis of the functioning of the drug supply system (PACFARM) and make recommendations for improvement. Additionally, the contractor will work with DIGEMID on the development of drug formularies. The Contractor also will supply technical assistance for the rational use of pharmaceuticals in up to 18 PCMI hospitals."

In 1996, PROVIDA, a Peruvian private organization specialized in pharmaceutical management, completed an assessment that was favorably reviewed by drug management specialists at Management

Sciences for Health (MSH) The study concluded the MoH Program for Shared Administration of Pharmacies at the Primary Level of Services (PACFARM), which supplies low cost pharmaceuticals to all the health centers and posts through 32 Regional and Subregional distribution centers, was functioning efficiently, but could be improved The report's findings and recommendations were presented and a copy of the report was given to the Regional Health Directors, MoH counterparts and DIGEMID Subsequently, PROJECT 2000 requested further MSH help and USAID bought into the USAID/W Project of Rational Pharmaceuticals Management of MSH The purpose was to improve the system, in particular to implement a revolving fund system to achieve financial sustainability of the PACFARM Program

Drug management is significantly improved since the PROVIDA study Regional and hospital staff in each hospital visited by the team related that costs of pharmaceuticals were down and income was up and drug management was easier Each hospital now has one central pharmacy in contrast to previous years, as noted in the study, when individual programs (ARI, TB etc) had individual drug supplies, some of which were not even appropriate to the program, generic drugs are accepted and supported by hospital staff and service providers

MSH's technical assistance, provided to date through five of eight scheduled workshops, has been very appreciated

7 INITIATIVES FOR EFFICIENT MANAGEMENT

Both the Management and the Financing Components got off to a slow start, especially considering that the person put in charge of them, the Health Economist, was originally funded for only four years (through February 1999) A number of factors contributed to the slow start (ANNEX 5)

7.1 The Demand, Cost and Financing Studies

One reason for the slow start of the Financing and Management Components was that the demand and cost studies, which were to provide input into the design of the national user fee system, were not completed until May 1996, 16 months into the Project

The cost study was well done The methodology it developed and employed became the standard approach adopted in several important subsequent studies It became the foundation of the Cost and Income Information System (Sistema Informatica de Costos y Ingresos, SICI) and is used to develop the health care services cost estimates that are an essential element in the Budget Programming System (Sistema de Programacion Presupuestaria, SPP)

The demand study was less successful, due to both financial constraints and technical decisions (ANNEX 6)

The demand, cost and health sector financing studies were among the first studies of this type in Peru in more than a decade They filled an important information void, and are regarded by many as important, pioneering, reference works The studies brought attention, credibility and respect to PROJECT 2000's efforts in the areas of financing and management, and laid the groundwork for the very considerable coordination and leveraging that the Project has achieved (further discussed below) The Health Economist has become a public health sector-wide recognized and respected leader in health care financing issues

7.2 Development of a National User Fee System

Two activities that were intended to provide input into the design of a national user fee system only have recently been started. These activities were (1) the development of an inventory of existing cost-recovery and efficiency enhancing schemes and (2) the selection of the most promising such schemes to (a) case study and (b) undertake operations research on to improve their performance. A number of considerations suggest that PROJECT 2000 has higher priorities at this time and that these two activities should be dropped (although currently contracted work should be completed)

- Presidential elections are only a year away, and there is no reasonable hope of establishing a national user fee system until some months after a newly elected administration has taken office,
- The type of information that was to have been obtained from these activities is now available from a number of recently completed studies, and
- most importantly, the Health Economist needs to focus her attention and Project resources on the SPP so as to better ensure that it is fully institutionalized and sustainable

User fee revenues have grown from 9% of all MoH revenues in 1992 to 15% in 1998. In absolute terms they grew from 12.7 million soles in 1991 to 213 million soles in 1998, a 17-fold increase. Moreover, there is evidence that they constitute an important barrier to access to care (Petrera, 1999). User fees remain an important issue that needs to be addressed, and PROJECT 2000 can still make a contribution, albeit a more limited one, to the public discussion on this important topic.

Recommendation

The GRADE contract to set up and assess two pilot user fee systems should be modified: the contract should be extended for an additional six months to provide more time for the system(s) to be established and up-and-running before it is assessed. Also, the user fee administrative systems—including the role of the DIRES in monitoring—must be made a primary focus of the study. The proposed public discussion of the objectives of a national user fee system (in an “Inter-campus-type event”) should be postponed until early 2001 (ANNEX 5).

8 HEALTH CARE FINANCING

8.1 Policy Dialogue

A condition precedent for USAID’s awarding PROJECT 2000 was that the Government of Peru establish an Inter-institutional Coordinating Committee (ICC). The ICC was seen as a potentially important vehicle for coordinating major health sector actors, while providing a forum for policy dialogue. The ICC was formed when PROJECT 2000 started, but met only three times and was never an effective tool of policy dialogue. Subsequently, another committee was formed that was charged with addressing health care financing issues. This was the Financing Committee, formed by MoH in mid-1995. The PROJECT 2000 health economist was the chair/coordinator of the Financing Committee from its inception until October 1997, when she stepped down. Since then the Committee has met sporadically.

The financial status of the MoH has improved significantly since the Contract was first drafted. In 1995, the Ministry's budget more than doubled from the previous year, and thereafter its funding level has remained relatively constant. As a result, the Financing Component has lost much of its urgency: it is no longer the *sine qua non*, for improving the functioning and quality of MoH care that it was when PROJECT 2000 was designed.

Moreover, a number of the major changes in the realms of financing and management of the Ministry which the Contract identified as important, potential topics for policy dialogue have been addressed, or are no longer relevant. This is the result of MEF budget development and monitoring reforms as well as some important changes in how the MoH allocates resources.

The MoH system is characterized by a plethora of idiosyncratic, facility-specific user fee systems that have come to constitute a barrier to access to care. Of the one-fifth of Peruvians who reported they were ill in the past four weeks and felt they needed to obtain health care but did not do so, 76% reported that they did not seek care because they could not afford it, i.e., 15% of persons who felt they needed care were deterred by economic considerations (Petrera 1999). There is a need for public debate on the objectives of a national user fee system. There also is a need for a continued coordination of the international agencies working in health. The growing coincidence of interests and activities in the health care financing, and the recent launching of the design phase of new IDB and World Bank Projects (both of which, it is reported, will be building on the work of PROJECT 2000), make coordination essential. While the Ministry's Health Financing Committee can play an important information sharing and coordinating role, the MoH needs to work more closely with MEF and MIPRE (which controls the health budget allocations to the Regions/Departments), and develop a permanent forum for doing so. User fees, inter- and intra-sectoral coordination, and the structure and administration of public health financing are all pertinent topics that should be reviewed and discussed by policy-makers on an on-going basis.

Recommendation

An inter-institutional committee should be reconstituted (See ANNEX 6 for details on potential topics and proposed committee members)

8.2 The Budget Programming System (SPP)

The Budget Programming System is undoubtedly the most significant output of the Financing and Management Components of PROJECT 2000. The SPP is a powerful and flexible electronic spreadsheet-based software program for establishing MoH service delivery goals and estimating both the unit costs and the total costs of providing those services.

This system represents an important break with the way MoH has established goals and developed budget requests in the past. Until the introduction of this system, most service delivery goals usually were established by each vertical program's national office, with non-vertical program service goals generally set by regional office personnel. The SPP is a tool for turning this top-down approach on its head: specific service delivery goals are established at the local level (the facility, the facility network or the DORES, depending upon exactly how it is implemented). MoH budget requests used to be extrapolations of the previous year's budget, and generally did not reflect either anticipated service delivery levels or the costs of providing care. The SPP is a vehicle for linking health plans, service delivery outputs, inputs and costs. Its application generates, and makes available for the first time, managerial information that is necessary, but not sufficient, for improving the performance of MoH personnel and facilities.

By providing a vehicle for expressing locally felt needs and priorities, and replacing the former top-down with a bottom-up approach, the SPP also may be regarded as an important tool for effective decentralization and the empowerment of local and regional MoH personnel. As such, like the PCMI system, it provides impetus to democracy-nurturing types of changes in the traditional mode of functioning of the State, and specifically the MoH. The significance of the development and successful implementation of the SPP cannot be overstated: it will usher in a new MoH era.

The SPP, however, is not yet fully implemented. In 1998, with assistance of the PSNB and the Pan-American Health Organization (PAHO), hosted SPP training and pilot-testing in the 12 PROJECT 2000 DIRES, the Callao DIRES and the eight sub-regions (networks) of the PSNB. Management Sciences for Health's (MSH's) Management Training and Planning (MCP) approach, which has just started to be implemented, looks well designed and as if it will be an important tool for helping to institutionalize the system. Nevertheless, the pilot-testing experiences and the feedback provided at a November 1998 national workshop of DIRES personnel and a March 1999 "SPP validation" workshop, suggest that it would be advisable to go a bit more slowly (MoH, PROJECT 2000 & PSNB, 1998).

The SPP officially has been adopted by the MoH's General Office of Planning (OGP) as the tool that it will use to develop budget requirement estimates that it annually submits to MEF. The MoH plans to use the SPP to develop the annual DIRES-level budget estimates for next year, 2000, but will be hard-pressed to achieve this goal. This goal underscores the overly optimistic view of implementing the SPP, which needs to be reassessed. The training and implementation phases of the SPP are critical and should not be short-changed. Doing so will put the institutionalization of this important innovation at-risk and will unnecessarily jeopardize the investment that has been made in its development to date.

Recommendations

Additional resources should be dedicated to the training, implementation, evaluation and follow-up of the SPP. Since this work will consist primarily of an increased level of effort by MSH and/or CIPRODES, this work should be awarded on a sole-source(s) basis.

Contracting a physician (Dr. Juan Lescano) to aid in presenting the SPP (and possibly the SICI) to physicians, overcoming their doubts and potential opposition to these systems, and shoring up their support for them has been a good strategy and should be continued. The position should be funded until at least June 2001.

Consideration should be given to developing and including an evaluation module in the basic SPP software package, as has been discussed in CIPRODES and MSH documents. To best ensure the timely delivery of this module as a fully compatible and integrated component of the SPP, this work should be awarded on a sole-source basis to CIPRODES.

Consideration also should be given to developing and introducing norms for calculating the "personnel" and "supplies and material" inputs and costs, rather than continuing to rely on annual re-calculations of the time and materials of each of the specific service delivery targets identified in the SPP (see ANNEX 6 for details).

CIPRODES should be (sole-source) contracted to develop an additional SPP software program to make the SPP compatible with MEF's SIAF.

It is noteworthy that the PSNB co-sponsored the November and March workshops, and that it is co-financing MSH's development and implementation of the SPP-specific application of the MCP and its associated training workshops. PAHO has co-financed and overseen SPP implementation in the Callao

DIRES, has hosted SPP review workshops and is actively involved in the MSH training workshops, as well

8.3 The Cost and Income Information System (SICI)

The development of this step-down cost analysis software tool is an important contribution of PROJECT 2000. It has been implemented in three hospitals (Huaras, Ayacucho and San Martín). It also has been introduced by the PSNB at the service network level in Piedra Liza (Lima), Yanacocha (Cusco), Chulucanas (Piura) and in Villa de Salvador (Lima Sur).

The following observations were made during a visit to the Huamanga Hospital in Ayacucho:

- The Economics Unit felt as though they were in a “state of war” with the physicians of the hospital. They report that many of the doctors are feeling threatened by the system and are sabotaging their implementation efforts.
- Not enough preparatory work was done to explain the SICI system and its use, or to establish a committee comprised of various types of staff-persons at the hospital to manage and direct the use of the system, and to oversee and ensure doctors’ provision of required data.
- Inadequate training/preparation for what to do with the database once it was developed, e.g., types of analyses that could be performed, demonstrating how SICI can aid management in making resource allocation decisions, and improve productivity and the efficiency of hospital operations.
- Staff reported feeling like “orphans,” i.e., that they had been largely abandoned by CIPRODES. They indicated that they felt they needed additional support and technical assistance.
- Staff reported verbal examples of staff responses to the cost findings, and apparent efforts to become more efficient. Also reported that analysis showed that 52% of food costs were incurred preparing food for staff, and led to the discontinuation of this staff subsidy.

CIPRODES reported that the decision to add a private ward to the Huaras hospital was based on cost analysis performed with the SICI.

Recommendations

Develop new components of the SICI software to incorporate analysis protocols to aid Economics Units in getting started in the analysis of the data.

Allocate additional resources for (1) developing institutional committees to support the implementation of the SICI and the use of its data, and (2) for bringing together Economic Units (e.g., Huaras, Ayacucho and San Martín) to share approaches, experiences, plans etc.

Sole-source contract MSH to develop a MCP module specifically for the SICI which incorporates the analysis protocols (see previous recommendation) and works with the PCMI-spawned matrix management sub-committees.

Current plans for introducing the system in five more hospitals starting this year should be carried out.

Inadequate attention was initially paid to assessing alternative hospital cost methodologies. This is now recognized and another approach (DRGs) is being investigated with the assistance of PHR Project. The SICI is likely to be too simple (inadequate precision) for the national hospitals and possibly larger regional hospitals. It is, however, adequate and appropriate for small hospitals and centers. (The larger, more complex facilities, are likely to have much more variability in the resource intensity of their cases, which will render the SICI's relatively small number of categories of patients less precise than the DRG costing system, with its 469 diagnostic categories.)

Recommendation

Complete the study of DRGs with the PHR Project

8.4 The Decentralized Management Improvement Model (DMIM)

The contract states that the DMIM and the Total Quality Management (TQM) activities "will not be undertaken until the cost-based planning program has been implemented and is running smoothly throughout the country." Decentralized management system was poorly defined in both the Project Paper and the Contract. PROJECT 2000 is currently reviewing bids on a request for proposals that it issued to conduct the DMIM activities.

Recommendation

Drop the DMIM activities, reallocate the DMIM budget to (a) the additional SPP and SICI activities recommended above, and (b) extending the Health Economist's contract. The time of the Health Economist that would have been devoted to DMIM should be re-allocated to (a) more closely monitoring and participating in SPP and SICI implementation, evaluation and follow-up activities, and (b) in the final year of the Project, to developing the synthesis policy paper described in the next section.

8.5 Develop Decentralized Budget Allocation System

PROJECT 2000 has conducted two studies addressing aspects of this issue. The OGP has specifically requested assistance in determining how to "distribute" its budget. This activity should be completed.

Recommendations

Extend the contract of the Health Economist to make it co-terminus with the rest of the Project (February 2002)

The 9 to 12 months of the Health Economist's time on the Project should be dedicated exclusively to writing a synthesizing policy document that analyzes (1) the user fee studies of PROJECT 2000 (CIUP, Cortez, and GRADE), PAHO, DFID and others, (2) discusses targeting strategies and lessons learned (including targeting via resource allocations and via user fee exoneration policy), (3) discusses the pros and cons of user fees versus insurance and the implications of relying on them simultaneously as demonstrated by analyses of the Maternal-Child Insurance and Student Insurance Programs, (4) discusses the lessons learned and future directions for cost-based reimbursement (using the SPP and SICI), (5) assesses the pros and cons of SICI versus DRGs in different types of hospitals, and (6) examines the integration of the SICI and the SPP. It is

imperative to develop this document, as the MoH currently has nobody capable of doing so and this type of thinkpiece is a critical, medium- and long-term strategic planning tool. Resources should be made available to enable the Health Economist to contract consultants who have worked with the Project and others to assist her in this work. The report should be presented at a national seminar during the final year of the Project.

9 SUSTAINABILITY

9.1 The Financing and Management Components

Indicators of the sustainability of the SPP

- The OGP has officially adopted the SPP and is planning to use it to develop the MoH budget request for fiscal year 2000, which will be submitted to MEF in May 1999.
- An "institutionalization" agreement has been drafted for OGP, PROJECT 2000, PSNB and PAHO to sign.
- The PSNB and PAHO have co-financed the implementation of the PROJECT 2000's SPP training and implementation package.
- World Bank and Inter-American Development Bank missions are visiting Peru in March-April 1999 to begin to design new health Projects, and both are expected to adopt the SPP as part of their new Project activities.

Recommendation

The draft "SPP institutionalization agreement" should be revised to identify specific required OGP inputs (equipment, training, new position descriptions, additional personnel, etc.) and to incorporate a timeline with deadlines for specific activities.

To date, there has been inadequate networking with MEF with either the SPP or the SICI. Discussions with MEF officials found them to be very interested and supportive of both of the SPP and the SICI initiatives. They need, however, to be brought into the process to better ensure that the systems are designed in a manner that is consistent with MEF's needs and requirements. This would greatly enhance the sustainability of both of these activities.

Since the start of PROJECT 2000, the UEP 2000 has insisted that it, and not Pathfinder or its subcontractors, is responsible for any extra-MoH communication or coordination. The UEP 2000 has not adequately fulfilled this responsibility. This is not surprising since the UEP 2000 has single-mindedly focused on the PCMI and neglected the Management and Financing Components of the Project. Pathfinder and/or the Health Economist, however, are not entirely without fault; they should have insisted that the UEP 2000 be more proactive and contacted MEF.

Recommendation

Now that contact between PROJECT 2000 and MEF has been initiated, both the UEP 2000 and the Health Economist should assume greater responsibility for cultivating and strengthening this relationship, and both should work together with OGP in doing so.

If PROJECT 2000 is awarded an extension, and the changes recommended here are made, it will greatly enhance the sustainability of the SPP and SICI outputs. By the end of the Project, the MoH will have had three years of experience using the SPP, and the system will be institutionalized. To date, the program has been implemented by existing staff in the DIRES, and has not increased the recurrent costs of the MoH. The SPP will be sustainable (at minimum, at the DIRES and OGP levels) by the end of the Project.

The SICI system, on the other hand, will still be located in only eight hospitals and five networks. While there will still be need for additional training as the SICI system is introduced in new sites, the development of hands-on capabilities within the MoH and the development of the MTP modularized program to support its implementation, should establish adequate in-house capabilities to replicate it elsewhere. From the very limited experience in implementing the SICI to date, it can be concluded that it will require adding at most two additional staff persons at each implementing facility to implement. This is not an undue financial burden, and should be sustainable in the institutions in which it is implemented.

If the SPP and the SICI can be integrated into the activities of the PCMI-spawned matrix management sub-committees, it would help to insulate these systems from the deleterious effects of the high turnover of staff with the marketable skills that are required to administer them.

9.2 The PCMI Component

As detailed elsewhere in this report, the content, structure and implementation of the PCMI component of PROJECT 2000 departs from its original design, and has been subject to further modification as the program has been implemented. There is uncertainty about the further development of the model, given the timeframe of PROJECT 2000. There is still unresolved discussion of what the second level of qualification should consist of, or how it should be implemented and assessed. Should the qualifying oversight committee be an MoH entity, or an outside agency, or some combination thereof? These fundamentally important, yet still unresolved PCMI-design questions obviously have important cost implications. The many modifications that have been made in PCMI, the still incomplete implementation of the Program, and the fact PROJECT 2000 has not "costed out" many activities, make it impossible to estimate the recurrent costs of the program, given the short time available for this evaluation team. This, in turn, makes it exceedingly difficult to ascertain the financial sustainability of PCMI, at this time.

Recommendation

PROJECT 2000 should "cost out" all components of its model, as part of the PCMI pilot approach, to better estimate the financial sustainability of PCMI.

- **The Cost of Qualification: A Sustainability Concern**

In addition to the PCMI's direct costs, there are substantial costs that are derivative of PCMI activities that must be taken into account when assessing the sustainability of PROJECT 2000. The most visible and important of these are the costs incurred by facilities striving to become "qualified." The UEP 2000 estimates (it is unclear how these estimates were developed) that the Qualification Program has cost an average of US\$16,000 to provide each participating facility with the materials (primarily equipment and supplies), training, and supervision they required in order to become qualified. This estimate suggests that the total cost for the 89 PCMI facilities to achieve their first qualification was roughly US\$1.4 million. This high cost has prompted the UEP 2000 to question the sustainability of the Project, and the feasibility of extending the Qualification Program throughout the country. This concern is underscored

by the likelihood that the second level of qualification will be more expensive than that which has been implemented to date (since it deals more with normative, technical skills and less with the basic, organizational-related issues of level one) However, as many of the initial start-up costs incurred as part of the "experiment" would not have to be repeated for a "second" level of qualification, the costs estimates may be substantially lower than estimated by UEP 2000

Given the protracted financing crisis of the MoH (1980-1994) it is likely that some portion of the outlays that the UEP 2000 has identified as necessary for qualification are actually expenditures required to get some facilities back up and running and to return others to some minimal acceptable standards for equipment and stocks of supplies (In the Ayacucho DIRES, for example, the Director reported that 56% of facilities were closed in 1992 due to terrorism) What proportion of the \$16,000 per facility has been specifically for, and only for, meeting qualification criteria has not been ascertained Other important, related questions include How often does qualification have to be done? How important is qualification as a tool for motivating MoH employees? Is its motivating force likely to decrease over time? If so what criteria will the Ministry use to determine the advisability of maintaining the program?

Recommendation

Undertake an analysis of the cost of the Qualification Program that distinguishes the costs incurred by the GOP for facilities (a) to achieve qualification and (b) those necessary to restore the general operational preparedness of facilities, as established in MoH accreditation norms

While the UEP 2000 has questioned whether the Qualification Program is adequately effective, given its apparent relatively high costs, all of the anecdotal data obtained by the evaluation team indicated that this Program is the critical motivating force that drives MoH facility staff in their Continuous Quality Improvement efforts Still, in light of its important and unknown financial requirements, it would be useful to have a better understanding of the dose-response relationship of the Program in order to be better able to design the program - determine the optimal frequency and duration of qualification - and do so in a manner that is as cost-effective as possible Indeed, this type of information is essential input into ascertaining the financial sustainability of the Qualification Program and PCMI It may be very difficult to do so, however the MoH (at all levels) is so excited about PCMI that it is introducing it in services and facilities outside of those targeted by PROJECT 2000 This will make it exceedingly difficult to design and effectively implement such a study, there simply will be too many confounding variables

It is noteworthy that while there has been a shortfall of PL-480 funding, the GOP and the MoH have more than offset this shortfall with public treasury financing Total counterpart funding has exceeded the level stipulated in the GOP-USAID Project Agreement The MoH's widespread interest in and universally enthusiastic support for the PCMI, together with the MoH's significant financial contribution to the Project augur well for the financial sustainability of the Project's interventions

The UEP 2000 has developed a document addressing this issue, "Propuesta de Transferencia y Sostenibilidad del Proyecto 2000 al Ministerio de Salud" While the need for this type of plan is apparent, this document is not adequately detailed For instance, it identifies 31 activities to be transferred to the MoH, but in identifying to whom each is to be transferred, it merely identifies one of the MoH's three levels (central, regional or facility) Moreover, there is no discussion of costs This proposal is foremost concerned with transferring responsibilities for various aspects of PROJECT 2000 to the MoH, or in some cases, others While a case can be made that this is an essential first step toward sustainability, this is not a sustainability plan

Recommendation

Before the end of PROJECT 2000, develop a detailed plan for ensuring the transfer and sustainability of PROJECT 2000 activities, using as a starting point the UEP 2000 document

9.3 Institutional

"Institutional sustainability refers to the capacity of the MoH and regional health authorities to plan, manage, administer, monitor, and adjust Project activities to ensure their effectiveness and continuity after Project completion "

On the operational level of individual service institutions, the potential for sustainability is excellent. MCH services professionals and workers have taken ownership of the CQI approach. Hospital directors and service providers point with obvious pride to what they have done to improve patient flow, monitor and increase patient satisfaction, improve physical facilities etc , - and say "This what WE have done ". The improvements are the result of their problem-solving, their concern and often their own physical labors (painting walls and making decorations for the clinics and hallways)

They are internalizing problem-solving and self-help through team-work and self-evaluation. Matrix organization and team-work are expanding individual perspectives and skills, which is the basis of institutional capacity-building. Though individual responsibilities and workload also are increased, workers appear to be rewarded by personal empowerment through demonstrable and tangible team success. As they chart service achievements, they see the increases in attendance, the increased client satisfaction and the better outcomes of serious cases. They are happier, feel empowered and effective. Standardized clinical practice appears to be now well accepted. As senior institutional leaders recognize the increased effectiveness of a motivated workforce, they completely endorse the program. The motivational factors are strong criteria for institutional sustainability. Additionally, the integration of vertical MCH and health programs into the PCMI problem-solving methodology, with some pooling of resources, not only further institutionalizes the PCMI approach directly, but also again indirectly. As integration benefits the institution's capacity for integrated problem solving, it engenders additional effectiveness that re-endorses the approach. The intra-mural spread from MCH services to other departments illustrates this effect.

A Caveat There are two key elements of PCMI that will drive the motivational engine of the establishments: the incentive structure provided by "Qualification" and re-qualification that must remain in place - with professional and technical credibility, both within and without the MoH. Moreover, the SIP objective performance record must become more familiar, more revealing and more rewarding with its information use, to reinforce the CQI process with continuing performance incentives.

A major concern High and rapid turnover of contracted personnel is a major concern for the sustainability of the approach for individual institutions. It is not only a cost issue, but breaks the continuity of intramural problem-solving. Though the MoH reportedly sees the staff turnover as a "reality" rather than as a "problem", in the short-run it can have a braking effect on the effectiveness of the PCMI quality improvements. In the long-term, provided that the MoH is willing to finance the costs of continuous "new Staff" training and re-orientation as they are moved, the total capacity of "PCMI-trained" personnel within the Project regions should be adequate for sustainability.

On the Ministerial Levels Program sustainability should lie almost exclusively with the DIRES, as the implementing authority. Not only is this locus consonant with GOP decentralization policies, but it is the only practical means of regionalizing the PCMI approach. PROJECT 2000 has actively involved the DIRES in the PCMI development and established a small core of PCMI-trained facilitators who oversee and assist the regional implementation, supervise, negotiate and problem-solve resources issues on behalf of PCMI. DIRES are actively involved in the administrative, technical, financial and political aspects of the program. They are well-versed and capable of sustaining these aspects of the program. And, equally important for sustainability, the regional health authorities clearly recognize the effectiveness of the PCMI approach. Some, like Puno, have already taken it far beyond the initial stages of implementation and are actively working on the referral systems and emergency care. This, together with the fact that the MoH has voluntarily contributed more of its own resources than required under the counterpart contribution into support of the PCMI program, and that local level "pasantias" extending PCMI training to health centers and posts are now supported by local funds from the national treasury, further gives a strong indication of potential MoH sustainability at the regional level.

Recommendations

- **Consolidate institutional gains and increase the motivational challenges with additional quality criteria and CQI goals for re-qualification**
- **Strengthen pro-active analyses and dissemination of SIP and service statistics to demonstrate gains and achievements. Consider other recommendations intended to promote visibility of results and competitive involvement in documentation of lessons learned, case studies**
- **Maximize documentation of lessons learned, problems solved and general learning from piloting of PCMI model**
- **Develop a PCMI human resources policy and MoH budget line for rapidly training and integrating new staff into PCMI operational teams. Conduct data-based analyses of contract staff movement to propose a rationalized staff movement policy, with terms of contract training clauses, i.e., if otherwise satisfactory, "pasantia" trainees commit to at least one-year post-training at their current service post**

9.4 Social

9.4.1 The PCMI Model

The PCMI model has demonstrated that it functions appropriately in the HC and CC organized networks and micro-networks. The community is changing the perception of the small and large changes in the health services. Also, health workers have a new competence in visualizing, expressing, and resolving problems improving their work environment.

The PCMI and its activities are sustainable in some places. PCMIs are perceived as a different and modern model that efficiently supports Health Reform. Many DIRES already have included, in their future plans, extension to other networks and micro-networks without the Project's support. They do it with their own resources or with Public Treasury resources via the UEP.

With regard to the community agents, PCMI has achieved a significant impact as demonstrated in the interviews held with community agents by the assessment team. The training, and materials delivered to the providers and midwives at the workshops are easily replicated given their simplicity and clarity.

The San Martin case illustrates the sustainability and opportunities of the PCMI. San Martin decided to extend the PCMI model to Lamas, what is noted in the field is the better practice of PCMI sustainability. As is proved in this example, the project has not yet concluded and the sustainability process is being developed.

These PCMI successes in the majority of the Project regions show the possibility of the model being extended to other regions.

Recommendations

To standardize and systematize all the PCMI elements and components to make it easy to replicate in other regions. During the Project extension, the present achievements should be consolidated and materials completed, and adjust the PCMI to the various characteristics of the regions covered by the Project. It is recommended monitoring the extension of the PCMI to other networks of the present regions because it will be an opportunity for fine tuning the PCMI for future sustainability in other regions.

The MoH and AID include a specific package geared towards the sustainability of the PCMI in the objectives of the Project extension.

UEP should coordinate very closely with the DIRES and the technical assistance everything relative to the implementation of sustainability.

9.4.2 IEC at the DIRES Level

PCMI has demonstrated that its benefits go beyond mother and perinatal health. The DIRES, HC and CC have confirmed that the method has been successfully applied to other subjects. In this context, what has been achieved with IEC has been one of the achievements that the PCMI incorporated into its plans. The activities developed in IEC in the different regions have resulted as appropriate for the PCMI even when the monitoring reports show different levels of achievement.

The IEC sustainability after the conclusion of the Project is possible if the role of IEC in the DIRES, HC and CC is worked on in-depth. The organization and formation of IEC units and the naming of IEC officers in the DIRES, HC and CC is one path to sustainability. Another opportunity for sustainability is to involve the team with the community through the IEC/CT.

Recommendations

At the central level, EAT should transfer all information on the PCMI IEC/CT to the MoH Directorate of Social Communication and to the Mother Child Directorate.

For IEC/CT sustainability in the different PCMI regions, EAT, UEP and the DIRES should sign agreements so that during the extension the level of skills of the teams in IEC/CT becomes uniform, ensuring that during the Project extension one of the objectives is met for developing sustainability strategies for the second year of the extension.

IEC/CT should involve the providers and midwives in the sustainability process so that they may convey the commitment and responsibility of demand in the sustainability of health services.

During the Project extension, IEC/CT should identify all the sustainability mechanisms that exist in diverse forms in each region.

10 PROJECT RESOURCES, TIME FRAME AND BUDGETS

The PROJECT 2000 bilateral agreement is for a \$30 million grant with \$30 million in matching counterpart funds. USAID authorized the \$30 million grant for the Project on September 30, 1993. The grant is divided into two parts: a technical assistance contract with Pathfinder International for \$19.7 million, with the remaining \$3.4 million to be managed directly by USAID. The sum of these components is \$23.1 million, leaving an unprogrammed balance of \$6.9 million. The original Project activity completion date was September 30, 2000. In its best and final offer, Pathfinder proposed that the Project be funded for an additional year.

As of September 30, 1998, \$18.8 million had been obligated, \$17.5 million had been committed, and \$13.5 million had actually been expended. It is anticipated that \$4.9 million will be spent in fiscal year (FY) 1999, bringing total cumulative expenditures of the Project to \$18.4 million. This will leave \$0.4 million in obligated funds unexpended, and \$11.6 in authorized funds unexpended.

As is evident in Figure 1, the Project's rate of expenditure of grant monies was relatively slow in its first two years, owing to major modifications that were made in the design of the core activities of the Project, viz., the content and approach of the PCMI. While the Pathfinder contract was signed in December 1994, and Pathfinder began working on the Project in April 1995, it was not until May of 1996 that there was agreement on what PCMI would consist. Moreover, it was another four months, September 1996, before the sub-contract with Consorcio ESAN was signed. The roll out of the PCMI, therefore, began only a little more than 1.5 years ago. It is estimated that the PCMI component of PROJECT 2000 is currently about two years behind the training implementation schedule, and that it is about 30% implemented.

As may be seen in Figure 2, substantially less PL-480 monies have been available than had originally been anticipated. PL-480 funds have not been available since FY1998, and total PL-480 counterpart financing currently totals 45% of the total originally programmed. Even with this shortfall of PL-480 financing, counterpart expenditures have been greater than required by the bilateral agreement. The shortfall of PL-480 monies has been more than offset by increased GOP treasury-financed expenditures. At the end of 1998, GOP treasury funds-financed expenditures were already 30 percent greater than the total \$8.0 million that the GOP had agreed to allocate to PROJECT 2000 over the entire life of the Project. According to the UEP 2000, the higher than planned level of expenditures of public treasury funds reflects two factors:

- the high regard the OFICE, the MoH and the GOP have had for the results achieved to date by PROJECT 2000, and particularly the PCMI component, and
- the much higher than anticipated expenditures on the difficult to plan for, still evolving PCMI model, and particularly its Qualification Program.¹⁷

At what level should the proposed extension be funded? Absent information on the cost of the PCMI, has made this a difficult question to answer. On the one hand, given the considerable learning-by-doing that has taken place under the Project, one would anticipate that on average it would cost less money on average per year to extend the contract than it has cost to support the program to date. Indeed, at least one of the most expensive activities of the Project—the building of the 14 lodging modules for national and regional PCMI trainees—has proven costly and should not be repeated. (They have, thus far, cost PROJECT 2000 roughly \$800,000, including the cost of supervision by an architect consultant, and

¹⁷ Expenditures were higher than expected due to needs being higher than expected, and the low level of services. In addition, most funds transferred by the MOH to the regions were spent on computers, module construction, supervision, and general Project monitoring/supervision, including PCMI activities.

overhead charges) On the other hand, as noted elsewhere in this report, there remain new activities yet to be defined and implemented The uncertainties involved, coupled with the remarkable success of the program to date, suggest the need to ensure adequate resources so as not to jeopardize the successes and the progress that have, thus far, been achieved in designing the PCMI Continued funding at the Project's 1998 level would appear to be warranted, yet prudent

ANNEX 1 LIST OF RECOMMENDATIONS

Re Project Extension

Extend funding to Pathfinder International to December 2001 (plus time for closeout) to enable the full development/completion of the activities presented in this report

The Contract between USAID and the IC should be revised so as to delete all language indicating that the MoH and its designated counterparts should approve "contract documents"

The new contract should be worded to reflect USAID reengineering in which USAID and those who work directly with USAID to affect the circumstances of customers are considered partners

A key component of the facilitated workshop on results, recommended previously, should be the PCMI problem-solving methodology to resolve conflicts, establish team work and increase professional collaboration among the three PROJECT 2000 partners

At the central level, PROJECT 2000 should meet soon with REPOSALUD staff to plan how they might learn from REPOSALUD's community-level knowledge of women's concerns and needs and incorporate that experience, including that on white menses, into making PROJECT 2000 even more effective in meeting women's needs

Re PCMI

Complete and consolidate the implementation of basic qualification and community activities in the current 89 health establishments Balance "horizontal" implementation in each of the 89 health establishments with targeted "vertical" quality increase (i.e., using SIP-analysis)

Design PCMI pilot vertical quality improvements, differentiated "Re-qualification" criteria and re-qualify a subsample of currently qualified establishments Test additional motivational goals, include recognition awards, prizes and competitions

Complete design of community component and demand creation, linked to clinical capacities Rapidly advance the development of clinical resolute capacities, pilot critical referral systems and community problem-solving around emergencies

Consolidate and reinforce use of protocols and SIP, especially in the peripheral service networks Use SIP analysis PCMI service improvements and results as motivational tools Disseminate Investigate SIP computer access and problem-solve

Plan, test and complete additional steps in pilot training/education and quality improvement approaches - self instruction, long-distance education, possibly pilot the introduction of PCMI approaches into basic professional education and training curricula, internships and residencies

In next Project phase document, evaluate and disseminate PCMI experiences and gains initiate systematic analyses with SIP and HIS service statistics Develop methodologies for simple investigations, analyses, case studies, etc., for documentation and as motivational tools

Re IEC

From the beginning of the extension, IEC and CT activities should start immediately and continue without restriction for the life of the Project. All administrative measures should be undertaken on a timely basis in 1999 so that there will be no delay in starting the extension activities.

In order to ensure the implementation of IEC and CT activities, a written agreement is needed with DIRES regarding the different sectors to establish priorities for cooperation in promptly carrying out IEC and CT activities. Also, a detailed implementation plan should be elaborated immediately for the 24 months from January 2000 to December 2001.

Focusing exclusively on PCMI's objectives and indicators, which need to be revised and agreed upon for the extension period, new objectives and indicators must be designed with absolute clarity as to what IEC and CT's involvement should accomplish in the 24 months of the extension.

Taking into account the following aspects which circumscribe the extension:

- The central recommendation of this evaluation, to consolidate that which has already been achieved by the PCMI
- The existence of various cultural barriers in the community in each location
- The size and location of the target group covered by the HC and CC which are organized in networks and micro networks in the PCMI
- The training already carried out with health-care providers, promoters and midwives
- The need to optimize USAID resources and the limited time available for IEC and CT activities during the extension
- It is recommended that the IEC and CT components be integrated into a single "IEC/CT" component

It is recommended that for the project's extension period, the "IEC/CT" component be designed as a component concentrating resources and efforts -- IEC methods and CT strategies for activities in the community with the participation of health-care providers and midwives.

It is suggested that MoH and USAID include outside technical assistance in the selection of objectives and indicators, in designing and planning of the "IEC/CT" component for the second and/or third trimester of 1999, and that they work with the present CARE/IEC team that is putting together EAT, as well as with the units and/or those responsible IEC individuals in DIRES, HC and CC in each location, so that the objectives, indicators, terms of reference, budgets, etc., may be realistically framed under the extension amendments' Scope of Work to include data helpful to the contractor and eventual subcontractors for focusing their activities and sharpening their output.

During the project extension the "IEC/CT" component must be carried out by two full-time IEC specialists experienced in community activities at the central level of EAT. Thus, it is recommended that the CARE IEC consultants, who make up part of the EAT team, have their term in the project extended and that the CARE subcontractor provide his assistance and technical support to these consultants.

The results of this research should be appropriately edited, published, and disseminated in the different areas where the data were collected.

In the last trimester of 1999, already trained local teams -- with outside technical assistance and using observation techniques -- should, in each location, determine the need to improve providers' skills in interpersonal communications with clients.

Feedback should be obtained through in depth interviews with health providers who have practiced the provider-user technique in order to correct training manuals

Review the cultural barriers still existing in each location, so that during the extension, those more likely to be resolved may be given provider/client and IEC/CT attention

Using existing information, it is recommended that the project work with community groups and IEC advisors to identify whether there are training needs to complement methodology and/or skills in order to achieve adequate impact-evaluation levels for IEC/CT by mid-year 2000

The EAT IEC consultants must support and track the process of technology transfer in those areas where it is decided to replicate the "IEC/CT" in the PCMI influence network and micro-network, thereby promoting sustainability

The IEC/CT plans should be designed for 24 months and incorporate a section on research findings, clear identification of the cultural barriers that have been given priority for behavior changes need to be suggested to health-care providers and to the target group of the community. This should permit design of the best involvement strategy for rural zones and allow for the successful delivery of messages with existing resources within the extension period

All providers and midwives in the different locations, who have been trained, should work with IEC/CT educational materials that are most appropriate for urban-rural and rural settings

The extension amendment SOW should be precise as to the products requested of the contractor and sub-contractors

The creation, design and validation of the materials production for the "IEC/CT" component should be done by the IEC groups or teams in each project location, and the production should be in response to each plan's strategy

In order to guarantee that the central and local production of materials be carried out without delays, it is recommended that a "production of materials Protocol" be developed, with a list of steps to be taken and timeframes to work within, in which all those involved should be considered and in which the critical route be identified. This protocol should be known and approved by all those who participate in the process

In order to ensure that the production of messages in each location achieves specific "IEC/CT" plan objectives, it is recommended that the "Thematic Matrix" be designed and included in the plans of the 24 month extension as a basic tool for producing messages. The model should consider the following variables

- MINSA standards for the subject
- Research results
- Cultural barrier
- Target group
- Subject content
- Channel to be used
- Period for the delivery of contents to the community

Each location has qualitative, quantitative, and local KAP research results, its own cultural barriers to resolve and each its own nuances. Thus, the production and distribution of "generic materials" is not recommended. This type of material, proper to the "umbrella campaign" strategy, is not applicable to the PCMI and does not fit in the "IEC/CT" strategy.

All products delivered to the project should have the validation of the target group who will use the product. The validation should have an understanding and total acceptance of the product. In the case of the manuals to be validated, in-depth interviews should be taken advantage of in order to make the necessary changes. This is an opportunity to provide adapted and specific manuals, following experimentation by the health providers of the provider-user technique that has been developed.

The printed material produced at the local level should have a footnote indicating the project name and number and the production date. All elements that do not have anything to do with the subject should be minimized or eliminated.

In order to appropriately collaborate with the transfer of technology at the central and local levels, the EAT IEC/CT component should standardize and systematize everything that has been produced and is to be produced for the project extension period. At the central level, the transfer should take place with two offices, the Maternal and Child Health and the MoH Social Communication office. At the local level, this transfer should occur with the IEC groups and/or teams of each DIRES covered by the project.

The systematization should include new formats as Rapid Reference Guides and/or Tool Manual for determined "IEC/CT" processes. In this context, the educational brochure should be considered for production at the end of the year 2000 and be a part of the systematization.

It is necessary to appropriately organize the technical assistance for the extension period in accordance with the present needs and requirements of the local IEC groups. It is recommended that the following structure and a certain scope should be clearly stated in the extension terms of reference.

- **The two CARE consultants in EAT positions** should focus their activities on the supervision of outside technical assistance, monitoring the local 24 month plans, and assessing the impact in IEC/CT. This general scope allows recommending that 70% of the consultants' time be spent in the areas providing the support of the local IEC/CT groups.
- **Outside technical assistance** is recommended to strengthen the providers' provider-user techniques, achieve uniformity in the level of methodology of the local IEC groups, train in IEC/CT impact assessment skills, locally support the provision of instruments to the promoters and midwives, and standardize some instruments for systematization. A period of 12 months of outside technical assistance would allow this scope to be met.

It is a requirement that all the IEC groups from the different locations achieve an appropriate level in order to receive IEC/CT impact assessment training.

As a principal means of reaching the community, the members of the local IEC groups should interact with the health-care providers and midwives in extracurricular activities. Thus, the local IEC plans should include the providers and midwives in a sphere of activities in the community.

During the PROJECT 2000 extension and period of technical assistance in IEC/CT, the focus of priority should be on consolidating what has already been achieved, completing the technical transference of the IEC/CT method to the different locations. During this extension period, it should be assured that the

IEC/CT activities meet their objective which lead demand to mobilize reasonably well, one has to assess whether this single intervention can saturate the Project's supply of HC and CC

The IEC/CT leaders at the central and local levels should be involved with the organizers and promoters of the next MATERNAL AND CHILD HEALTH INSURANCE, whose media campaign at the national level is expected to be quite frequent. Launching this campaign will, no doubt, impact the mobilization of demand in the Project areas, thus making unnecessary the broadening of IEC/CT activities through the social marketing of services. The supply will be covered with all these variables and events foreseen in the extension.

However, understanding that there will be many opportunities in which the local IEC teams will be gathered for various types of workshops, it is recommended that, when the uniformity in the level of IEC methodology has been reached, the IEC teams be informed about social marketing and its opportunities in the community.

Re Support Systems

USAID, the UEP 2000 and IC should work together, through a facilitated workshop¹⁸, to come to consensus on the desired and realistic results to be achieved at the end of the extended Project. They should explicitly

- Redefine the purpose and scope of the Project
- Redefine population-based indicators based upon that scope
- Set targets based upon 1996 DHS data
- Revise the Project objectives in light of current realities and possibilities, and establish indicators
- Integrated PCMI results with results in finance and management (related to institutionalization and sustainability)
- Define, if possible and appropriate, service utilization outputs in PCMI-related facilities, and establish indicators
- Define service outputs in PCMI-related facilities and establish indicators
- Come to consensus on functional outputs and the process for achieving them

PROJECT 2000 should continue promoting the PCMI supervision approach developed and shared to date. It should continue working on processes to enable complementary and mutually reinforcing supervision of PCMI-assisted activities by the external groups listed above.

Re Initiatives for Efficient Management

The GRADE contract to set up and assess two pilot user fee systems should be modified: the contract should be extended for an additional six months to provide more time for the system(s) to be established and up-and-running before it is assessed. Also, the user fee administrative systems—including the role of the DIRES in monitoring—must be made a primary focus of the study. The proposed public discussion of the objectives of a national user fee system (in an “Intercampus-type event”) should be postponed until early 2001. (See ANNEX 5 for further details.)

¹⁸ Project 2000 should ask Pathfinder to recruit a two-person team to lead the workshop: one person should focus on problem-solving and conflict resolution. The other would be a health resource person who could assist with the conceptual framework, particularly in terms of population and program-based indicators.

Re Health Care Financing

An inter-institutional committee should be reconstituted

Additional resources should be dedicated to the training, implementation, evaluation and follow-up of the SPP. Since this work will consist primarily of an increased level of effort by MSH and/or CIPRODES, this work should be awarded on a sole-source(s) basis.

Contracting a physician (Dr. Juan Lescano) to aid in presenting the SPP (and possibly the SICI) to physicians, overcoming their doubts and potential opposition to these systems, and shoring up their support for them has been a good strategy and should be continued. The position should be funded until at least June 2001.

Consideration should be given to developing and including an evaluation module in the basic SPP software package, as has been discussed in CIPRODES and MSH documents. To best ensure the timely delivery of this module as a fully compatible and integrated component of the SPP, this work should be awarded on a sole-source basis to CIPRODES.

Consideration also should be given to developing and introducing norms for calculating the "personnel" and "supplies and material" inputs and costs, rather than continuing to rely on annual recalculations of the time and materials of each of the specific service delivery targets identified in the SPP. (See ANNEX 5 for details.)

CIPRODES should be (sole-source) contracted to develop an additional SPP software program to make the SPP compatible with MEF's SIAF.

Develop new components of the SICI software to incorporate analysis protocols to aid Economics Units in getting started in the analysis of the data.

Allocate additional resources for (1) developing institutional committees to support the implementation of the SICI and the use of its data, and (2) for bringing together Economic Units (e.g., Huaras, Ayacucho and San Martín) to share approaches, experiences, plans, etc.

Sole-source contract MSH to develop an MCP module specifically for the SICI which incorporates the analysis protocols (see previous recommendation) and works with the PCMI-spawned matrix management sub-committees.

Current plans for introducing the system in five more hospitals starting this year should be carried out.

Complete the study of DRGs with the PHR Project.

Drop the DMIM activities, reallocate the DMIM budget to (a) the additional SPP and SICI activities recommended above, and (b) extending the Health Economist's contract. The time of the Health Economist that would have been devoted to DMIM should be re-allocated to (a) more closely monitoring and participating in SPP and SICI implementation, evaluation and follow-up activities, and (b) in the final year of the Project, to developing the synthesis policy paper described in the next section.

Extend the contract of the Health Economist to make it co-terminus with the rest of the Project (February 2002).

The 9 to 12 months of the Health Economist's time on the Project should be dedicated exclusively to writing a synthesizing policy document that analyzes (1) the user fee studies of PROJECT 2000 (CIUP, Cortez, and GRADE), PAHO, DFID and others, (2) discusses targeting strategies and lessons learned (including targeting via resource allocations and via user fee exoneration policy), (3) discusses the pros and cons of user fees versus insurance and the implications of relying on them simultaneously as demonstrated by analyses of the Maternal-Child Insurance and Student Insurance Programs, (4) discusses the lessons learned and future directions for cost-based reimbursement (using the SPP and SICI), (5) assesses the pros and cons of SICI versus DRGs in different types of hospitals, and (6) examines the integration of the SICI and the SPP. It is imperative to develop this document, as the MoH currently has nobody capable of doing so and this type of thinkpiece is a critical, medium- and long-term strategic planning tool. Resources should be made available to enable the Health Economist to contract consultants who have worked with the Project and others to assist her in this work. The report should be presented at a national seminar during the final year of the Project.

Re Financial Sustainability

The draft "SPP institutionalization agreement" should be revised to identify specific required OGP inputs (equipment, training, new position descriptions, additional personnel, etc.) and to incorporate a timeline with deadlines for specific activities.

Now that contact between PROJECT 2000 and MEF has been initiated, both the UEP 2000 and the Health Economist should assume greater responsibility for cultivating and strengthening this relationship, and both should work together with OGP in doing so.

PROJECT 2000 should "cost out" all components of its model, as part of the PCMI pilot approach, to better estimate the financial sustainability of PCMI.

Undertake an analysis of the cost of the Qualification Program that distinguishes the costs incurred by the GOP for facilities (a) to achieve qualification and (b) those necessary to restore the general operational preparedness of facilities, as established in MoH accreditation norms.

Before the end of PROJECT 2000, develop a detailed plan for ensuring the transfer and sustainability of PROJECT 2000 activities, using as a starting point the UEP 2000 document.

Re Institutional Sustainability

Consolidate institutional gains and increase the motivational challenges with additional quality criteria and CQI goals for re-qualification.

Strengthen pro-active analyses and dissemination of SIP and service statistics to demonstrate gains and achievements. Consider other recommendations intended to promote visibility of results and competitive involvement in documentation of lessons learned, case studies.

Maximize documentation of lessons learned, problems solved and general learning from piloting of PCMI model.

Develop a PCMI human resources policy and MoH budget line for rapidly training and integrating new staff into PCMI operational teams. Conduct data-based analyses of contract staff movement to propose a rationalized staff movement policy, with terms of contract training clauses, i.e., if otherwise satisfactory, "pasantia" trainees commit to at least one-year post-training at their current service post.

Re Social Sustainability

To standardize and systematize all the PCMI elements and components to make it easy to replicate in other regions. During the Project extension, the present achievements should be consolidated and materials completed, and adjust the PCMI to the various characteristics of the regions covered by the Project. It is recommended monitoring the extension of the PCMI to other networks of the present regions because it will be an opportunity for fine tuning the PCMI for future sustainability in other regions.

The MoH and AID include a specific package geared towards the sustainability of the PCMI in the objectives of the Project extension.

UEP should coordinate very closely with the DIRES and the technical assistance everything relative to the implementation of sustainability.

At the central level, EAT should transfer all information on the PCMI IEC/CT to the MoH Directorate of Social Communication and to the Mother Child Directorate.

For IEC/CT sustainability in the different PCMI regions, EAT, UEP and the DIRES should sign agreements so that during the extension the level of skills of the teams in IEC/CT becomes uniform, ensuring that during the Project extension one of the objectives is met for developing sustainability strategies for the second year of the extension.

IEC/CT should involve the providers and midwives in the sustainability process so that they may convey the commitment and responsibility of demand in the sustainability of health services.

During the Project extension, IEC/CT should identify all the sustainability mechanisms that exist in diverse forms in each region.

ANNEX 2 SCOPE OF WORK AND REVISED OUTPUT MATRIX

SCOPE OF WORK
(Project No 527-0368)
Mid Term Evaluation of Project 2000

I. Background

Project 2000 (No 527-0368) is implemented under a bilateral agreement signed between the Governments of Peru and the United States of America on September 29, 1993. The goal of this seven-year US\$ 30-million grant is to improve the health and nutrition status of young children and women of childbearing age. The purpose of the Project is to increase the use of child and maternal health interventions.

The Project seeks to increase an appropriate use of child and maternal health interventions while, through community-based promotive and preventive activities, it will decrease the need for curative care, thus contributing to a greater efficiency in facility-based services. The project also addresses issues of sustainability, maintaining that higher levels of appropriate utilization can be achieved only if services are made more sustainable by becoming more available, accessible and acceptable.

In order to achieve its goal and purpose, the project takes a three pronged approach by (1) providing support directly to child and maternal health services, (2) improving the efficiency of those services through improved management, and (3) supporting the financial sustainability of those services through improved health financing.

As a way of focusing USAID supported interventions and rationalizing donor resources in Peru, Project 2000 targets twelve geographic areas: Ayacucho, Chavin, Chanka-Andahuaylas, Huancavelica, Ica, La Libertad, Lima-East, Moquegua, Puno, San Martin, Tacna, and Ucayali.

To facilitate project management and ensure appropriate technical assistance, the main project activities are being implemented through an Institutional Contractor (IC), Pathfinder International, who relies on overall policy and technical guidance from the MoH and USAID/Peru. The IC was selected in December 1994, through competitive bidding, via a selection committee comprised of representatives of both the MoH and USAID. The full team of the IC which is known as the "Equipo de Asistencia Tecnica (EAT), or Technical Assistance Team began work in February 1995.

Most Project technical and financial resources are devoted to the first component **Strengthening Child and Maternal Health Services**, which provides assistance to priority health and nutrition programs and is expected to result in a visible reduction in infant, young child and maternal deaths, as well as improvements in nutrition status. The other two components are "enabling" components that contribute to

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the long-term viability of child and maternal health services and help ensure the future of those services

The first project component, **Strengthening Child and Maternal Health Services**, helps to expand the coverage and improve the quality of national child and maternal and perinatal health programs, pregnancy and delivery care, acute respiratory infections, with emphasis on pneumonia, infant and young child nutrition immunizations, and diarrheal diseases. Because existing child survival programs in Peru have appreciably reduced infant deaths due to immuno-preventable and diarrheal diseases, Project 2000 places the greatest emphasis on programs that target the major killers at the time of project design -- perinatal complications and acute respiratory diseases, as well as on malnutrition, as a major contributing cause of mortality and a serious impediment to child growth and development. Project 2000 has not placed great emphasis on strengthening family planning services because other USAID activities have been providing assistance to the Family Planning Program of the MOH. There are, the PASARE Program and Cobertura con Calidad. Therefore, strong coordination is required among these three interventions.

The second project component, **Initiatives for Efficient Management**, aims at decentralizing administration and improving the management of resources and budget levels for child and maternal health programs. To support this component, the EAT is charged with developing pilot activities in the project priority areas in decentralized management improvement and total quality management, all of which are geared toward increasing the quality and efficiency of health care services. ~~These pilot programs are to be reviewed and evaluated for their potential replication by other donors.~~ In addition, under this component the EAT is charged with introducing a cost-based programming and budgeting process into the MoH that will help the MoH rationalize its budget requests and disbursements. Finally, under this component the project provides short term and long term training opportunities in public health and program management.

The third component, **Health Care Financing**, supports MoH efforts to augment resources for primary health care through increased mobilization of funds and strengthened efficiency. Among other issues, it strives to increase the amount of the public sector budget available for child and maternal health services. This and such other issues as decentralization, the budget allocation process, budgetary segmentation, cost recovery and possibilities for public/private sector collaboration are being addressed through policy dialogue with relevant GoP entities and health sector donors. Other efforts related to cost recovery and equity of service provision to low-income populations focus on the development of rational user fee and cost recovery systems. Studies on cost analysis of health services and on health care demand will help EAT make recommendations for user fees, fee exemption criteria and cost-containment mechanisms.

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II Project Description

The specific tasks originally designed under each component, including a brief explanation of major changes, are the following.

1. Strengthening Child and Maternal Health Services**A Clinical Training Program**

The outputs to be obtained under this sub component are the following

- A 1 Reports on qualitative, formative research on the views, beliefs and practices of community women, trained and untrained traditional birth attendants, and health personnel, in the area of maternal and perinatal health, as well as other relevant maternal and child health topics for which good data do not presently exist. The research should be conducted in the priority areas**
- A 2 Establishment of a major training center in Lima for birth related health, diarrheal disease, ARI, breastfeeding, weaning and growth monitoring**
- A 3 Development of curriculums in maternal/child health in areas where updated sound curriculums do not already exist.**
- A 4 Accomplishment of two observational and training visits to out-of-country programs to obtain updated information and training materials on maternal-perinatal health and health care**
- A 5 Adaptation of materials obtained in these visits for application in Peru**
- A 6 One pilot course, eight pilot replica courses, nine training-of-trainer courses, 80 model hospital courses, 128 community training/health promoter courses and 128 traditional birth attendant courses in birth-related health**
- A 7 One pilot training program, 8 pilot replica courses, 8 training-of-trainer courses, 136 model hospital courses and 180 community training/health promoter courses in ARI/DD**
- A 8 One pilot training program, 8 pilot replica courses, 8 training-of-trainer courses, 136 model hospital courses and 180 community training/health promoter courses in breastfeeding, weaning and growth monitoring**

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- A 9 Procurement of relevant basic equipment, supplies and medicines and distribution to health establishments, along with appropriate training in their use
- A 10 An implemented system for perinatal information (SIP) in four of the model hospitals, as a way of monitoring quality of care. This SIP should be complementary and compatible with the MoH's HIS/MIS system

The inputs for this sub component are the following

- Provide administrative and technical assistance to develop and implement the above-mentioned training
- Conduct ethnographic research within the priority areas
- Procure office equipment and materials for the office of the master training center
- Supply the model hospitals, primary health care facilities and health promoters with appropriate training materials, equipment and supplies, so that they are equipped to use new training in daily clinical practice
- Supply TBAs involved in the training with birthing kits.

Comments

Training The training-related outputs numbers two to seven proposed in the original contract underwent changes in design and implementation. An alternative proposal submitted by a group of institutions headed by ESAN (Escuela de Administracion de Negocios) was selected through a competitive bidding process by a committee comprised of representatives of USAID and the Ministry of Health. The evaluation team will analyze the implementation of the current training model, determine its likely effectiveness in reaching project objectives, and assess its potential for sustainability upon project completion. The training program under implementation is described in a separate document.

Research Regarding the ethnographic studies, two major studies are in the process of execution: one on traditional practices in childbirth and newborn care, and the other on community audits on cases of maternal mortality. The evaluation team will determine the relevance and usefulness of the findings and recommendations to be offered to health authorities and health services in order to make services more culturally acceptable to rural populations, and also to be used to inform the content of IEC activities.

Equipment and medicines These items were bought and delivered by the MoH with counterpart funds (PL480-III)

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Perinatal Information System (SIP) As a way of supporting the training system and take preventive measures to reduce maternal and infant mortality, the decision was made to increase from 4 to 90 the proposed number of health establishments that implement the SIP. These are the same establishments that participate in the training program (PCMI).

Birthing kits for TBAs. Prior to PCMI implementation, which includes training of TBAs, the MoH provided counterpart funds to the Health Regions to conduct some training for TBAs, and provide birthing kits. In September 1997, discussions started by Consorcio ESAN with regional authorities on regional experiences with participation of community health promoters and TBAs in order to organize the training program at local level, using the new methodology proposed by the PCMI.

B Information, education and communication (IEC)

The outputs expected under this sub-component were the following

- Development and pretesting of key messages in maternal and perinatal health ARI and other relevant topics, keyed to the priority areas
- Local-level IEC packages for the priority areas that encompass the maternal/child health topics of the project
- A series of community-based educational activities in priority areas that utilize the IEC packages to stimulate people to promote their own health
- Regional seminars and workshops
- Self-instructional materials, including videos, for health personnel and community-level health workers in maternal/child health topics
- A continuing educational bulletin or supplement to an existing MoH publication that will keep MoH personnel current on maternal/child health topics. The periodical should be published regularly, with a print run of at least 6,000, and provision should be made for distribution costs
- A communication campaign that educates the public about the national user-fee system
- A national mass media campaign, if deemed necessary, that encompasses educational messages in maternal and perinatal health

The inputs to be provided under this sub component are the following

- Conduct qualitative research in the priority areas
- Provide technical assistance to design and implement the community-level IEC activities

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Comments.

To provide assistance in the implementation of this component, the EAT sub-contracted the services of the Center for Communication Programs of the Johns Hopkins University, Institution with long-standing international experience in IEC programs, which has an agreement with the Global Bureau of USAID/Washington, Office of Population JHU/CCP conducted a rapid needs assessment study before designing the specific intervention activities. Based on this study and previous experiences of the MoH in IEC activities, the decision was made to a) integrate training efforts in IEC with the PCMI, since interpersonal communication is an important aspect of quality of services for service providers and community agents, b) place emphasis on training to strengthen communication skills of health workers to reach rural communities and reduce cultural barriers between health providers and service clients, using information provided by the ethnographic studies and ReproSalud Project and c) instead of developing national mass communication campaigns, the priority was placed in development of skills of health staff to design and implement culturally acceptable IEC strategies, development of messages to be transmitted by radio or other appropriate means accessible to rural communities. Moreover, it was expected that the Basic Health and Nutrition Project financed by the World Bank was going to conduct national health and nutrition communication campaigns.

Educational Bulletin A bulletin on maternal and child health topics is being produced and distributed by the PCMI to the health establishments.

Mass communication campaign on user fees. The MoH decided to eliminate this activity since it was not consistent with the objectives of the Health Sector Reform process of the MoH.

C. Support Systems

The following outputs were included under the support systems sub-component

- An assessment of the presently functioning Health Information System (HIS) and continued strengthening of the system, with emphasis on the priority areas
- An information system component, integrated with the presently functioning HIS/MIS system, that tracks Project 2000's indicators within the priority area
- An enhanced training program for MoH personnel in the priority areas that covers, not only the Project 2000 tracking system, but training in the management of the information that is currently being tracked by the HIS/MIS
- A decentralized monitoring and supervisory system in the priority areas. This includes design and development of the system, training in the system for MoH personnel and resources for its implementation.

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- An improved and functional procurement, storage and distribution system for the MoH's supplies and medicines with emphasis on the priority areas

The following inputs were proposed under the support systems program

- Provide short-term technical assistance for the assessment and strengthening of the HIS/HIS system.
- Supply technical assistance to develop and conduct follow-up assistance to supervisory system, and training in the system
- Supply technical assistance and follow-up assistance to design the logistics system
- Supply technical assistance to procure the medicines and supplies and to support the actual distribution process
- Design and implement an enhanced HIS/MIS training course for the priority areas
- Design and implement a supervisory training program in the priority areas
- Supply training to appropriate MoH personnel in the new logistics system Pilot the logistics training program in the priority areas and the MoH will replicate the training nationally
- Provide the necessary additional equipment for the HIS/MIS system
- Procure and supply HIS/MIS training materials
- Procure four-wheel drive vehicles to be used for supervision
- Supply the equipment and materials necessary to support the new logistics system.

Comments:

HIS system. The health information system (HIS) was developed and implemented at the national level during the previous USAID financed Child Survival Action Project (527-0285) The second module called Management Information System (MIS) to process administrative information was not developed After a long process of discussions with relevant counterparts in the MoH, including the Strengthening Health Services Program, financed by the IDB the decision was made to conduct an evaluation study of the HIS system in each of the Project Regions to submit specific findings on the quality, timeliness and use of the information provided by the system to different levels of health authorities, starting from the first level health services Based on this study the MoH will

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make a decision about the health information system. The period of conduction of this study is August 97-January 98

Vehicles for supervision: They were bought, through a public bidding process, by the MoH with counterpart funds (PL480-II) and distributed to the 12 regions and subregions. The EAT bought and use 4 vehicles for their supervision activities, one located in Lima and three for the regional advisors located in Trujillo (La Libertad), Huamanga (Ayacucho), and Puno (Puno)

Pharmaceutical logistics system An evaluation study was completed in September 1996 by PROVIDA, a Peruvian private organization specialized in pharmaceutical management, under contract with Pathfinder. The study was reviewed by experts of Management Sciences for Health with favorable comments. The report findings and recommendations were presented and a copy of the report was given to each one of the Regional Health Directors, MoH counterparts, in particular DIGEMID (Directorate of Drugs and Medicines of Peru), institution equivalent to the US/FDA. One of the functions of DIGEMID is the purchase and distribution of pharmaceuticals through the network of health facilities.

Since July 1994, the MoH has implemented the Program for Shared Administration of Pharmacies at the Primary Level of Services (PACFARM) that supplies with low cost pharmaceuticals to all the health centers and posts through 32 Regional and Subregional distribution centers. According to the study, this Program is functioning efficiently, however it requires some adjustments and improvements. The Project and USAID have requested technical assistance from Management Sciences for Health/Rational Pharmaceuticals Management to DIGEMID to improve the system, in particular to implement a revolving fund system to achieve financial sustainability of the PACFARM Program.

2 Initiatives for Efficient Management

The outputs to be delivered under this sub-component were the following:

- Development and implementation of a national-level of a national cost-based programming and budgeting system
- A decentralized management improvement model piloted in two priority areas.
- A total quality management model piloted in the same areas as the decentralized management improvement model
- Quarterly coordination and evaluation meetings that include the MoH central office and program managers in the priority areas
- A core group of MoH officials trained in the most current management practices in the field of public health

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The Inputs expected under this sub-component were the following

- Provide technical assistance to develop and implement the cost based programming and budgeting system
- Provide technical assistance to develop and implement both the decentralized management improvement models and the total quality management models
- Train 60 MoH officials in the new cost-based programing and budgeting system
- Train 40 MoH officials in the decentralized management improvement models and total quality management pilot systems
- Design and implement an in-service management training programs for all levels of managers within the priority areas
- Fund short-term, out-of-country training for 50 MoH officials and (possibly) long-term, out-of-country training at the Master's degree level for 15 MoH officials
- Procure all supplies and equipment necessary for the training under the management component. Supplies and equipment should be adequate for the priority areas

Comments.

Cost-based budgeting system. Under this component, a study was conducted by Alfa Consult to analyze the budget design methodology used at the national and regional levels and a new budgetting system based on costs was designed and proposed to the MoH and Health Regions. This proposal was consistent with that established by the Ministry of Economy and Finance, through the annual General Budget Bill for 1998. Technical assistance was provided by the Project to the Regional and Subregional officers responsible for 1998 budget preparation, and submission in July. For the preparation of the 1999 budget, the Project will conduct complementary training and technical assistance during the first semester of 1998.

Total quality management model. The EAT has incorporated this management approach in the PCMI training. The organization of services has been identified as a major obstacle to attain high quality of services, along with the technical competence and interpersonal communication. In consequence, Directors and physicians of maternal and child services are being trained in the methodology of problem analysis, and during the training period they develop a quality improvement plan for their own services to be carried out after the training seminar (called "pasantía").

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To support the quality improvement processes of MCH Services started under PCMI, the Project has trained Service Directors in management of services and perinatal techniques in the PAHO Latin-American Center of Perinatal Health (CLAP) in Uruguay. In addition, they have participated in workshops on management of quality services by Management Sciences for Health.

With the objective to obtain support for the service improvement groups originated by the PCMI, and start quality improvement processes at the Hospital level, the Project has financed the participation of 18 PCMI Hospital Directors to a three week Workshop on Management for Quality offered by Management Sciences for Health in Cuernavaca, Mexico during October - November, 1997.

Decentralized management: This activity was not clearly defined in the contract. Improvement in the preparation of local annual budgets will contribute to obtain more resources for their regions, and will also contribute to decentralization of decisions on the allocation and management of financial resources. During the Project Review meeting in August 1997, USAID, the MoH and the IC agreed on the provision of assistance for the organization and implementation during 1998-99 of an Economic and Financial Analysis units in each of the 10 Regional and Subregional hospitals participating in PCMI, including the application of Revenues and Costs registration and their analysis, similar to the Unit created, under a pilot experience financed by the Project, in Victor Ramos Guardia Hospital in Huaraz. This pilot activity was not originally included in the Project Paper, but it was a request made by the Regional Director of Region Chavin. During the end of 1997 and early 1998, a second pilot experience will be implemented before expanding it to the proposed number of hospitals.

3 Health Care Financing

The outputs to be produced under this sub-component were the following:

- Design and implement a National fee structure based on the national cost and demand studies
- Advocacy in policy dialogue on management and financing reforms
- An inventory of existing efficiency-enhancing and cost-recovery efforts in Peru
- The results and recommendations of a series of studies that assess existing cost recovery schemes, conducts operations research on new ones, and develops case studies on a few of the most promising schemes

The inputs to be provided under this sub-component are the following:

- Supply technical assistance to design and implement a national fee structure, drawing on the nationally-based cost and demand studies

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- Conduct at least eight and not more than ten studies of current and potential cost recovery efforts within Peru

Comments

Tariff system Guidelines for the design of tariffs and exoneration schemes will be designed by the IC. In addition to this, activities for dissemination of the guidelines will be conducted in Project regions, and criteria for tariff setting and exonerations will be validated in a group of health establishments

Cost-recovery In August 1997, the MoH, the IC, and USAID reached consensus to do operational research on the two most frequent cost recovery schemes applied in Peru, private clinics within public sector hospitals and pre-paid schemes in public sector hospitals and health centers. These analyses will provide information on two schemes that could be used to serve low and middle-income populations that have no access to some health insurance, and will not have access to health insurances in the near future

III. Purpose of the Evaluation

This evaluation has four objectives. First, it will assess progress toward achievements of project objectives and identify and analyze the reasons of any shortfall. This calls for an evaluation of the changing environment and conditions and an assessment of whether the IC, the MoH, and USAID have acted adequately in their respective to these changes. Furthermore, the evaluation team will make recommendations as to how the IC, the MoH, and USAID can improve their management and involvement in this project. The second objective of the evaluation is to evaluate the financial, institutional and social sustainability of the project and make recommendations to enhance significant progress in all three by the end of project life. The third objective is to analyze the project's resources, budgets, and time-frame, and assess any future need for modifications. The fourth objective is to identify any other factor that have had positive or negative impact on project implementation.

Objective One

The evaluation team will assess the performance of (1) Pathfinder International as IC and technical assistance provider, (2) Ministry of Health (MoH), and regional health authorities in their role in general Project guidance, monitoring and supervision; and health services as implementing entities, (3) USAID, as funding agency, in its support for implementation and monitoring of project activities, coordination with the MoH and other donors since project inception in September 1993

The evaluation team shall evaluate the progress achieved to date in carrying out planned implementation tasks under each project-supported MoH program and support system, as stipulated in the Project Grant Agreement, Institutional Contractor Contract, Annual Operational Plans, Monthly and Annual Reports, document the current status of each project component/tasks, identify and analyze the reasons for any shortfall, and provide

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recommendations to improve their implementation and add or delete specific components and tasks, if necessary.

The evaluation will take into consideration that subsequent to the Project Paper design during 1992-93, political, social and economic changes have taken place in the health sector, in particular within the health sector and the MoH. In response to these changes, the IC, in agreement with the Ministry of Health and USAID, has modified some of the originally designed activities to accommodate Project activities to the changing conditions. The evaluation team will analyze the appropriateness of the modifications made in project activities to attain the proposed objectives.

Some specific questions the evaluation team will answer regarding implementation of project activities are:

1. Is the PCMI training model improving the quality of maternal and child health services in the proposed period? Would these changes contribute to reduce maternal and child perinatal mortality? Is the Perinatal Information System (SIP) being utilized to detect risks and prevent complications in pregnancies and deliveries?
2. Information, education and communication: Are the proposed activities going to help reducing cultural barriers to health services? Did the IEC plans and activities incorporate the findings of the rapid assessment made by JHU/CCP, ethnographic studies made by P2000, and qualitative studies made by ReproSalud Project?
3. Did the health information system study provide timely and useful information to make decisions regarding the current information system used by the MoH?
4. Regarding the logistics systems, did the findings of the study made by the project were used to improve the logistics system at the central level or at regional levels?
5. Are the General Office of Planning of the MoH, and project regions and subregions implementing the budgeting methodology based on costs? Is this methodology an instrument for decentralized management?
6. Is the cost and income system (SICI) being utilized and the economic analysis unit functioning in the Victor Ramos Guardia Hospital? If so, what benefits has the hospital obtained from this experience? Is this experience being replicated in other hospitals?
7. Did the studies on costs, Demand and Financing provide useful information to the MOH to make decisions to improve the health financing system?

The MoH Project Unit performance in fulfilling their project implementation responsibilities will be specifically evaluated regarding the following:

1. Liaising with USAID/HPN in formulating overall project policy and making major Project management decisions

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2 Providing guidance to the IC in Project implementation, and coordination with the IC in the financing of project activities in regions

3 Ensuring that project activities are carried out by the MoH counterpart, in accordance with the terms and conditions in the Project Agreement and annual workplans and budgets

4 Facilitating the coordination of project inputs and activities with programs at the central level of the MoH and between the central and regional levels,

5. Ensuring the efficient and appropriate use of counterpart-financed technical advisors, commodities and vehicles,

6. Ensuring that PL-480 funds programmed under the Project reached the regional levels in a timely manner

7. Submitting annual detailed plans for the use of any Project funds (donation) provided directly to the MoH

Additionally, the team shall evaluate USAID performance regarding its overall project monitoring responsibility, including the following

- 1 Directly procuring the services of appropriate institutions to carry out the cost study and demand study
- 2 Directly procuring the services of the IC
- 3 Overseeing and guiding the IC activities
- 4 Reviewing and approving workplans, and sub-contracting activities, and modification proposals.
- 5 Providing feedback to the IC and MoH on project implementation

Objective Two.

By financial sustainability we mean the capacity to recover or otherwise generate the financial resources needed for the continuity of activities without additional USAID support. Institutional sustainability refers to the capacity of the MoH and regional health authorities to plan, manage, administer, monitor, and adjust project activities to ensure their effectiveness and continuity after project completion. Social sustainability connotes community ownership of some project activities, in particular the training of community agents developed by the PCMI

Some specific questions that the evaluation team will address are

- 1 Is the PCMI training model, including the community agents component, sustainable upon project completion? Is it likely to be expanded out of project regions?

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2 Is the IEC project component developed to complement adequately the PCMI? Is this sustainable upon project completion?

3 Is the SICI being used in the Victor Ramos Guardia Hospital in Huaraz? Is it likely that the SICI system going to continue being used after project completion?

4 Is the budgeting system based on costs a management tool that could continue to be used after project completion Is it likely to be used out of project areas?

Objective Three

The contract between USAID and Pathfinder, in its section F states that the contract may be extended to continue provision of some or all of the services provided during the initial contract period for up to one (1) additional year The evaluation team will analyze project's resources, time frame and budgets, and will assess any needs for modification, including the need for the one year additional contract extension, and recommend activities that would be carried out in the additional period

Objective Four

Identify other factors that have had negative or positive influence in project implementation

1 How the organizational structures of the Ministry of Health, Regions, and Subregions, have influenced in Project implementation?

2 Has the coordination of P2000 with other MoH projects or other USAID Projects located in the same geographical areas, been made at the central level or at the field level? What outcomes have been experienced?

3 What other factors have had positive or negative outcomes for project implementation?

IV The Evaluation Team and Its Level of Effort

It is recommended that the team consists of four members fluent in Spanish The team should include,

1 Health management expert

Training Medical Doctor or Social Scientist with Masters Degree or Ph D in Public Health, Health Program Management or related field

Experience Eight to ten years of experience in management and evaluation of maternal, perinatal and child health care programs in developing countries
Experience in leading and direction of evaluation teams

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Abilities and skills Fluent in Spanish and English, good leadership and writing skills

2 Health training specialist

Training. Health professional or Educator with Masters Degree in Public Health or related fields

Experience Eight years experience in the organization, conduction, and evaluation of health training programs, including health promoters, in developing countries, preferable in Peru or Latin America Experience in training methodologies particularly for adult education

Abilities and skills. Ability to communicate with multiple social groups and ability to work in teams Fluent in Spanish and English, and good writing skills

3. IEC expert

Training BA/Master in Social Communication, Psicology, Education, Anthropology or related fields

Experience At least eight years experience in management and evaluation of information, education and communication of primary health care strategies, including community participation activities, preferable in Peru or other pluri cultural countries in Latin America

Abilities and skills: Fluent in Spanish and English, ability to work in teams, ability to communicate with multiple social groups, and good writing skills

4 Health economist

Training Economist or Social Scientist with Masters Degree or Ph D in Economics, preferable in Health Economics or Health Management

Experience At least five years experience in management or evaluation of health services, in particular in health financing issues Knowledge and experience in health financing reform processes of public health services

Abilities and skills: Fluent in Spanish and English, good writing skills, and experience in teamwork

The management expert will be the team leader At least one member of the team will be an expert in gender issues, preferable the IEC expert

Qualifications of the team need not rigidly adhere to these individual descriptions as long as all skills are represented in the team as a group

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The team leader will have a time commitment of 32 working days, and the other three team members will be contracted for 28 working days. It is required that all the team members spend at least ten working days in project regions, outside Lima.

V. Evaluation Methodology

The evaluation will be developed and carried out with the full participation of Ministry of Health, central level, the Project Special Unit, and Health Regional authorities, USAID/Peru, EAT(Pathfinder) and other institutions and persons involved in P2000, in the recognition that these development partners are all working toward the same goal. This evaluation should be viewed as a management tool that will help guide the project to a successful completion and a thriving future.

All pertinent project documents will be made available to the evaluation team. The Project Paper, Project Agreement, contract with EAT, selected studies, and other key documents will be sent to the team before it travels to Lima, so that all members are well-versed in the basics of the project upon their arrival. Each team member will have two days to review the basic project documents.

Their on-site work should include interviews with MoH, USAID/Peru, EAT staff, sub-contractors, staff of selected Health Regions, health personnel, key community leaders and anyone else considered necessary. At the regional levels, interviews will also be conducted with MoH authorities, EAT regional advisors, hospitals, health centers and health post staff, and community leaders. Visits and observation of maternal and child health services is highly recommended.

The evaluation team will design its work to be as participatory as possible, engaging all of the project's stakeholders in the process. With this in mind, the evaluation team will present findings and recommendations to all the key people involved with the project, through a meeting, giving them the chance to integrate, evaluate and respond to the report and its recommendations.

VI. Reporting Requirements

1. **Workplan.** The Contractor will prepare a detailed workplan, which shall include the methodology to be used, and submit it to USAID/ HPN for approval. This should be submitted after the third day on-site (in Lima).
2. **Preliminary Report.** The Contractor will submit to the Health Population and Nutrition Office (HPNO), eight copies of the preliminary report four in Spanish, which will include key findings and recommendations. These findings and recommendations will be presented in a debriefing at the USAID/Peru Mission. This preliminary report will also be presented to the MoH staff and EAT, as described in Section IV above. The Results Package Team at USAID, Pathfinder.

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International and the MoH will have ten working days after the debriefing to send comments and suggestions to the team leader. The team leader will address the comments in the final report

- 3 Final Report. The Contractor will submit ten copies of the final report in English and other ten in Spanish to USAID/Peru no later than four weeks after the comments on the preliminary report are received by the Contractor. The document should also be supplied on a diskette using the WordPerfect Software. This final report may include recommendations for variations, besides those already made by the EAT in agreement with the MoH and USAID, in the design, goals, activities and budget structure. It should be no more than 50 pages long, including and Executive Summary. Supporting data should be included in appendices.

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Project 2000
Outputs indicators

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
Reports on formative research on the major health topics of the Project, with messages for the priority areas derived from this research	<ul style="list-style-type: none"> Major research topics have been identified 	<ul style="list-style-type: none"> Study report "Identification of Knowledge Gaps in Maternal & Child Health in Peru by Dr Luis Codina and Dr Manuela de la Peña Study report "Design of Guidelines for Community Health Workers Training Plan' by Lic Flormarina Guardia Terms of reference for the studies 'Maternal Mortality Cases Study' and ' Traditional Techniques of Delivery and Newborn Care" by Lic Paola Naccarato 	<ul style="list-style-type: none"> 11-29-1995 05-31-1996 08-09-1996
	<ul style="list-style-type: none"> Appropriate research institutions have been selected 	<ul style="list-style-type: none"> Subcontract with Catholic University to perform the "Maternal Mortality Cases Study" Subcontract with San Marcos University & Centro Flora Tristan to perform the study "Traditional Techniques of Delivery and Newborn care" 	<ul style="list-style-type: none"> 09-01-1997 07-01-1997

	<ul style="list-style-type: none"> • Formative research on priority health topics has been conducted 	<ul style="list-style-type: none"> • "Maternal Mortality Cases Study" final report by Catholic University • "Traditional Techniques of Delivery and Newborn Care" final report by San Marcos University and Centro Flora Tristan 	<ul style="list-style-type: none"> • 01-02-1998 • 03-02-1998
	<ul style="list-style-type: none"> • Research results have been presented and discussed with MoH officers 	<ul style="list-style-type: none"> • Study results presentation meeting 	<ul style="list-style-type: none"> • 08-07-1998
	<ul style="list-style-type: none"> • Research results have been disseminated among health sector institutions 	<ul style="list-style-type: none"> • Studies results publication and distribution 	<ul style="list-style-type: none"> • In process

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
Establishment of a training program in reproductive, maternal perinatal and child health (PCMI) The PCMI will be implemented using a long term local subcontractor	<ul style="list-style-type: none"> PCMI has been designed by Project 2000 and approved by the MoH 	<ul style="list-style-type: none"> Resolucion Vice Ministerial No 465-96-SA 	<ul style="list-style-type: none"> 09-11-1996
	<ul style="list-style-type: none"> A local long term subcontractor has been selected for PCMI implementation 	<ul style="list-style-type: none"> Subcontract with Consorcio ESAN for PCMI implementation 	<ul style="list-style-type: none"> 09-06-1996
	<ul style="list-style-type: none"> The MoH has formed a PCMI Coordination Committee which is in charge of strategic program decisions 	<ul style="list-style-type: none"> PCMI Coordination Committee first minutes of constitution 	<ul style="list-style-type: none"> 11-07-1996
	<ul style="list-style-type: none"> 12 MoH regions/subregions have formed/reinforced training units which are in charge of the PCMI implementation in their areas 	<ul style="list-style-type: none"> Signed agreements between Consorcio ESAN and each region/subregion 	<ul style="list-style-type: none"> Oct-Nov 1996
	<ul style="list-style-type: none"> 18 training hospitals (HC) and 72 training centers (CC) have completed the first program phase ("pasantia") 	<ul style="list-style-type: none"> Consorcio ESAN's product 50 Consorcio ESAN's product 68 Consorcio ESAN's product 87 Consorcio ESAN's product 106 	<ul style="list-style-type: none"> 08-19-1998 10-09-1997 12-11-1997 04-21-1998
	<ul style="list-style-type: none"> 18 HC and 71 CC have installed continuous quality improvement process in maternal and child health services 	<ul style="list-style-type: none"> Consorcio ESAN's product 53 Consorcio ESAN's product 69 Consorcio ESAN's product 72 Consorcio ESAN's product 88 Consorcio ESAN's product 107 	<ul style="list-style-type: none"> 07-14-1997 12-10-1997 02-02-1998 02-02-1998 05-28-1998

<ul style="list-style-type: none"> • 18 HC and 71 CC have passed external evaluation of basic quality level 	<ul style="list-style-type: none"> • Minutes of the PCMI Coordination Committee meetings 	<ul style="list-style-type: none"> • From Nov 1996 to date
<ul style="list-style-type: none"> • A distance learning methodology has been designed and tested 	<ul style="list-style-type: none"> • Consorcio ESAN s product 161 	<ul style="list-style-type: none"> • Pending
<ul style="list-style-type: none"> • 2373 health centers and posts have completed the third program phase (local pasantia" or distance learning training) 	<ul style="list-style-type: none"> • Consorcio ESAN s product 78 • Consorcio ESAN's product 114 • Consorcio ESAN s product 122 • Consorcio ESAN's product 138 • Consorcio ESAN s product 148 • Consorcio ESAN s product 156 • Consorcio ESAN's product 165 • Consorcio ESAN's product 175 	<ul style="list-style-type: none"> • 04-21-1998 • 07-23-1998 • 07-23-1998 • 12-03-1998 • 12-21-1998 • Pending • Pending • Pending
<ul style="list-style-type: none"> • An assessment of MoH and NGO experiences with Community Health Workers (CHW) has been performed • Training materials for CHW have been collected and analyzed 	<ul style="list-style-type: none"> • Consorcio ESAN's product 29 • Consorcio ESAN's product 46 	<ul style="list-style-type: none"> • February 1997 • August 1997

<ul style="list-style-type: none"> • CHW training of trainers materials have been developed and tested • CHW training of trainers activities have been conducted 	<ul style="list-style-type: none"> • Consorcio ESAN's product 71 • Consorcio ESAN's product 83 	<ul style="list-style-type: none"> • January 1998 • January 1998
<ul style="list-style-type: none"> • CHW training activities have been conducted 	<ul style="list-style-type: none"> • Consorcio ESAN s product 79 • Consorcio ESAN s product 96 • Consorcio ESAN s product 124 • Consorcio ESAN s product 127 	<ul style="list-style-type: none"> • Jan 1998 • Nov 1998 • Dec 1998 • Nov 1998

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
Local-level IEC activities for the priority areas that encompass the maternal/child health topics of the Project	<ul style="list-style-type: none"> • IEC strategy has been designed and approved by the MoH • 12 regions/subregions have formed/reinforced IEC units which are in charge of activities implementation • A Rapid Assessment on IEC Needs has been performed in the regions • Personnel from regional IEC units have been trained in IEC strategic planning • IEC regional units have conducted and analyzed KAP studies on maternal-perinatal health in their areas • IEC local campaigns are implemented by regional units on a regular basis 	<ul style="list-style-type: none"> • Letter of approval from P2000 UEP • Letters of acceptance from 12 Regional Directors • Approval and presentation of results • Workshop reports • Signed agreements with regions • Presentation of results • IEC materials have been designed and distributed • IEC activities reports from regions 	<ul style="list-style-type: none"> • 12-08-1996 • February 1997 • May-June 1997 • Aug 1997 to Jan 1998 • Jun-Aug 1997 • Feb 1999 • In process • In process

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
Self-instructional materials for health personnel and community-level health workers on maternal/child health topics	<ul style="list-style-type: none"> Printed instructional materials for health personnel have been developed and tested Printed instructional materials for community health workers have been developed and tested Multimedia instructional materials for health personnel have been developed and tested 	<ul style="list-style-type: none"> Consortio ESAN s product No 112 Consortio ESAN s product 45 Consortio ESAN s product 60 Consortio ESAN's product 62 Consortio ESAN s product 74 Consortio ESAN's product 92 Consortio ESAN s product 143 Approval of final version of Perinatal Information System Tutorial Approval of final version of AIEPI Tutorial Approval of final version of Perinatal Technologies Tutorial Approval of final version of Neonatal Resuscitation Tutorial 	<ul style="list-style-type: none"> 09-22-1998 Aug 1997 Nov 1997 Jan 1998 Jan 1998 Sept 1998 Mar 1999 June 1996 June 1997 Oct 1998 In process

Output	Indicators	Data Source /Completion status report due 1999	Completion date
<p>A continuing education bulletin or supplement to an existing MoH publication that will keep MoH personnel current on maternal/child health topics</p>	<ul style="list-style-type: none"> A continuing education bulletin for health personnel has been developed and tested 	<ul style="list-style-type: none"> Consortio ESAN's product No 41 Consortio ESAN s product No 55a Consortio ESAN's product No 55b Consortio ESAN s product No 73 Project 2000 Informative Bulletin Project 2000 First Years Project 2000 Informative Bulletin Project 2000, An effort for the Country's Health 	<ul style="list-style-type: none"> 02-19-1997 11-03-1997 12-15-1997 04-13-1998 December 1996 1997 1998 1998

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
An evaluation of the presently functioning HIS	<ul style="list-style-type: none"> • Evaluation goals have been determined • An appropriate subcontractor has been identified and selected • The evaluation has been performed • The evaluation results have been presented and discussed with MoH officers 	<ul style="list-style-type: none"> • Terms of reference for the study "Assessment on quality, processing and use of information of the HIS and National Programs information systems" • Contract with Calmet Data • Approval of the study final report • Presentation Meeting to MoH officers 	<ul style="list-style-type: none"> • Oct 1996 • May 1997 • Apr 1998 • Apr 1998

Output	Indicators	Data Source /Completion status report due 1999	Completion date
Improved management of medicines in the 18 PCMI-related hospitals	<ul style="list-style-type: none"> • Evaluation of the status of the MoH drugs logistic system has been performed • A quality improvement program in Rational Drugs Use has been established in the 18 PCMI-related hospitals 	<ul style="list-style-type: none"> • Final Report of the study "Logistic Systems of Essential Medicines and Supplies" • Workshops on Rational Drugs use • Strengthening of Hospitals Pharmaceutical Committees • Design of Pharmaceutical Formularies • Mid-Term Hospitals Self-Assessment • External evaluation 	<ul style="list-style-type: none"> • Jan 1997 • From May 1998 and continuing • From May 1998 and continuing • From May 1998 and continuing • January – February 1999 • Pending

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
An information system component that tracks Project 2000 indicators within the priority areas	<ul style="list-style-type: none"> • Main areas of interest for project's tracking have been determined • A set of indicators and data gathering procedures has been developed and tested 	<ul style="list-style-type: none"> • Consorcio ESAN's product 37 • Consorcio ESAN s product 132 • Maternal Mortality explanation model • PCMI Coordination Committee agreement on first level qualification indicators • Workshop on SIP analysis and Prenatal and Delivery Care Quality indicators • Workshop on Analysis of Maternal-Perinatal Service Quality Indicators" • PCMI Coordination Committee agreement on re-qualification indicators 	<ul style="list-style-type: none"> • 02-16-1998 • 12-17-1998 • 10-19-1998 • 02-16-1998 • 12-05-1997 • 07-13-1998 • In process

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
A decentralized monitoring and supervisory system	<ul style="list-style-type: none"> An assessment of current MoH supervision system has been performed and an improved supervision model has been developed and discussed with MoH officers Methods instruments and procedures for the improved supervision model have been developed MoH central and regional officers have been trained to use the new supervision model methods, procedures and instruments 	<ul style="list-style-type: none"> Consortio ESAN's product 52 Technical Assistance to the Internal Client (TAIC) supervision model approved by MoH Consortio ESAN's product 52 Consortio ESAN s product on TAIC instruments and procedures Workshop on supervision abilities Training on TAIC instruments and procedures 	<ul style="list-style-type: none"> 10-10-1997 10-05-1998 10-10-1997 Pending 04-20-1998 Pending

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
A national-level cost-based budget programming system (BPS)	<ul style="list-style-type: none"> • Diagnosis of current MoH budgeting system has been performed • An improved budgeting model has been developed and discussed with MoH officers 	<ul style="list-style-type: none"> • Subcontract with MACROCONSULT S A to perform the 'Assesment of current MOH budgeting system' and Analysis of public health expenditure" 	<ul style="list-style-type: none"> • 03-28-96
	<ul style="list-style-type: none"> • Methods, instruments and procedures for the improved budgeting model have been developed in accordance with the new budgeting methodology determined by Ministry of Economy and Finance (MEF) 	<ul style="list-style-type: none"> • Subcontract with Alpha Consult S A to perform the 'Design of the Budgeting and programming System (BPS) 	<ul style="list-style-type: none"> • 03-17-97
	<ul style="list-style-type: none"> • Training and implementation of the BPS in the 12 regional/subregional offices MoH central and regional officers have been trained for using the new budgeting model methods procedures and instruments 	<ul style="list-style-type: none"> • Subcontract with CIPRODES S A for the implementation of BPS training plan in the 12 regional/subregional budget offices 	<ul style="list-style-type: none"> • 08-31-98
	<ul style="list-style-type: none"> • Coordination with MOH's Basic Health and Nutrition Project (BHNP) for training and implementation of the BPS in other 8 regional/subregional offices 	<ul style="list-style-type: none"> • Subcontract with CIPRODES S A for the adjustment of the BPS software • Subcontract with MSH to develop and implement auto-instructive modules for BPS implementation under MCP methodology 	<ul style="list-style-type: none"> • In progress • In progress

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
A decentralized management improvement model piloted in two hospitals	<ul style="list-style-type: none"> • Analysis of payment mechanisms options • Development of payment mechanism for regional hospitals with technical assistance from PHR • Terms of reference Decentralized Hospital Management Program (DMIM)" 	<ul style="list-style-type: none"> • Study "Guidelines for the design of new payment mechanisms for public providers • Report "Regional and hospital survey" • Report Clinical data requirements for hospital payment reform" • Request for proposals for DMIM and selection process in progress 	<ul style="list-style-type: none"> • 11-30-98 • 11-15-98 • 1-15-99 • In progress
A total quality management model piloted in the 18 PCMI hospitals	<ul style="list-style-type: none"> • A TQM model for maternal & child health services has been developed and approved by the MoH • Personnel from maternal & child health services of the 18 PCMI training hospitals have been trained in the TQM model concepts, methods, procedures and instruments • Directors of the 18 PCMI training hospitals have been trained in TQM 	<ul style="list-style-type: none"> • Document Continuous Quality Improvement of Maternal & Child Health Services approved by MoH • Workshop on TQM in MCH services for Department Chiefs • Course on TQM in MCH services for Midwives and Nurses • Course "Quality Assurance Management in Cuernavaca-Mexico 	<ul style="list-style-type: none"> • 10-05-1998 • 4-14-1997 • 08-23-1998 • 10-27-1998

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
Quarterly coordination and evaluation meetings that include USAID, the MoH central office and program managers in the priority areas	<ul style="list-style-type: none"> USAID, the MoH and the technical assistance team have periodical meetings to evaluate and feedback the project implementation 	<ul style="list-style-type: none"> Monthly, quarterly and annual reports 	<ul style="list-style-type: none"> From Feb 1995 to date
A core group of MoH officials trained in the most current management practices in the field of public health	<ul style="list-style-type: none"> MoH local officers have been trained in the implementation of perinatal technologies in maternal & child health services MoH regional officers have been trained in the management of the Perinatal Information System MoH regional officers have been trained in supervision abilities Directors of the 18 PCMI training hospitals have been trained in TQM Regional MoH officers have been trained in health economics basis 	<ul style="list-style-type: none"> Workshops on Perinatal Technologies 68 SIP regional experts trained Workshop on Supervision Abilities Course 'Quality Assurance Management' in Cuernavaca-Mexico Report of the seminar "Health Sector Modernization Process" 	<ul style="list-style-type: none"> 11-11-96 5-5-1997 4-7-1997 4-14-1997 Set-Dec 1996 4-20-1998 10-27-1998 05-19-1997

Ouput	Indicators	Data Source /Completion status report due 1999	Completion date
A validated proposal for a user fee system for health services of the MoH	<ul style="list-style-type: none"> • Develop guidelines for MoH Targeting and Tariff Policy • Design a user fee and exemption system in public health facilities • Develop a strategy to validate the proposed system • Implement the validation strategy in two areas • Provide recommendations to extend the system and its mechanisms and the instruments throughout the country 	<ul style="list-style-type: none"> • Report "Guidelines for MoH Targeting and Tariff System" • Subcontract with GRADE for the design and validation of the tariff and exemption system" 	<ul style="list-style-type: none"> • 09-15-99 • In progress
The results and recommendations of a series of studies on cost recovery	<ul style="list-style-type: none"> • Studies on cost recovery experiences 	<ul style="list-style-type: none"> • Terms of Reference 	<ul style="list-style-type: none"> • In progress

Outputs not included in the contract amendment

Output	Indicators	Data Source /Completion status report due 1999	Completion date
A tested design of a Referral Maternal & Perinatal Care System	<ul style="list-style-type: none"> • Technical proposal approved by MoH • Baseline assessment performed in two local health facility networks • Local implementation plans approved in two local health facility networks • Local plans have been implemented 	<ul style="list-style-type: none"> • USAID-Project 2000 technical meeting report • Reports from regional authorities • Approval of plans by regional authorities • Monitoring and evaluation reports 	<ul style="list-style-type: none"> • 02-12-1999 • In progress • Pending • Pending
A study of demand for health Services in one province	<ul style="list-style-type: none"> • Development of a demand study for health services in the province of Huaras 	<ul style="list-style-type: none"> • Subcontract with Universidad Pacifico for development of a demand study for health services in Huaras 	<ul style="list-style-type: none"> • 12-15-98

Output	Indicators	Data Source /Completion status report due 1999	Completion date
Development and implementation of the Information System on Costs and Income (ISCI)	<ul style="list-style-type: none"> • Development and implementation of the Cost and Revenue Information System (SICI) in the Hospital Victor Ramos Guardia de Huaras- Ancash • Implementation of the Cost and Revenue Information System (SICI) in the Hospital de Apoyo de Huamanga- Ayacucho 	<ul style="list-style-type: none"> • Subcontract with CIPRODES to design and implement the Cost and Revenue Information System (SICI) • Subcontract with CIPRODES to implement the Cost and Revenue Information System (SICI) 	<ul style="list-style-type: none"> • 08-30-97 • 26-02-99
Resource mobilization for health services (Policy Dialogue)	<ul style="list-style-type: none"> • Coordination of the "MoH Financing Committee , for the discussion and coordination of project activities in the health care financing area • Coordination of the Technical Interinstitutional Group 	<ul style="list-style-type: none"> • Periodical meeting reports • Report "Health Sector Financial Flows 1995-96) 	<ul style="list-style-type: none"> • On going • 10-30-97

Output	Indicators	Data Source /Completion status report due 1999	Completion date
Research on health economics	<ul style="list-style-type: none"> Research on health economics by Huaras university students 	<ul style="list-style-type: none"> Report "Analysis of demand for health services for children in the province of Huaras" Report Efficiency and productivity of maternal and child services" 	<ul style="list-style-type: none"> 2-15-99 In progress

ANNEX 3 PERSONS CONTACTED/INTERVIEWED

USAID

Mr John Cloutier, Mission Deputy Director
Dr Susan Brems, Jefa de la Oficina de Salud Poblacion y Nutricion
Dr Luis Seminario Carrasco, Oficial P2000
Eco Maria Angelica Borneck, Coordinadora P2000
Eco Myriam Choy, PDP/Especialista en Evaluacion
Ms Barbara Feringa, Senior Technical Advisor
Mr Allen Eisenberg, Regional Contracts Officer
Adrian Fajardo, Economist

Ministry of Health MoH/MINSA

Oficina de Financiamiento, Inversiones y Cooperación Externa (Ofice)
Dr Augusto Meloni, Director

Oficina General de Planificación/MINSA
Dra Doris Lituma, Directora de la Oficina General de Planificación/MINSA

Dirección General de Salud de las Personas
Dr Jesus Toledo, Director General

Programa Salud, Mujer Niño
Lic Miryam Strul, Directora del Programa y Asesora de la Dirección de Salud de las Personas

Maternal and Perinatal Health Program
Dr Nazario Carrasco, Director

UNIDAD ESPECIAL PROYECTO 2000
Dr Hugo Oblitas, Director del Proyecto 2000, MINSA
Dr Neptali Santillan, Equipo de Gestion
Lic Maria Casas, Equipo de Gestion
Dr Eduardo Aguirre, Equipo de Gestion

Supervisores UEP2000/MINSA
Lic Gabriela Samillan (San Martin, La Libertad, Huaras)
Dra Lucy del Carpio (Ayacucho, Huancavelica, Andahuaylas)
Dr Eduardo Garrido (Puno, Moquegua, Tacna, Ucayali)
Dr Benjamin Lino (Ica, Lima Este)

LIC MIGUEL MERINO, DIRECTOR OF INVESTMENT

Sr Dante Briones, Director of Rationalization
Sra Gladys Gomez Rodriguez, Director General, Office of Statistics
Sra Martha Honoree, Executive Budget Office, General Office of Planning

Ministerio de Economía y Finanzas (MEF)

Hedy Haracaya, Director, Dirección Nacional del Presupuesto Público

Doris Villanueva Masgo, Sectorialista de Salud, Dirección Nacional del Presupuesto Público

Otros

Lic Margarita Petrerá, Health Economist, PanAmerican Health Organization

Hedi Huaracaja, Health Sector Specialist, Ministry of Economy and Finance

Martha Cecilia Esteves D , Administrative Director of Consorcio (ESAN)

Gladys Soto de García, Gerente de Finanzas, CARE

Vilma Montañez, Sub-Director, Proyecto Salud y Nutrición Básica del Banco Mundial

Ing Elias Lozano Salazar, consultant, Technical Assistance Team (EAT)

Illich Ascarza Lopez, President, CIPRODES, Analistas en Asuntos Económicos, Sociales, Contables y

Legales S A

INSTITUTIONAL CONTRACTOR (Pathfinder International)

Equipo de Asistencia Técnica P2000 (EAT)

Sr Michael Jordan, Jefe EAT

Dr Bruno Benavides, Jefe Adjunto

Dr Rene Cervantes, Especialista Capacitación

Dr Alfonso Villacorta, Especialista Materno-Infantil

Lic Flor Marina Guardia, Especialista Salud Comunitaria

Eco Midori de Habich, Economista de Salud

Lic Ruben Telles, Consultor IEC

Asesores Regionales EAT

Dr Ricardo Dios (Sede La Libertad)

Dr Jose Lizarraga (Sede Ayacucho)

Dr Raul Miranda (Sede Puno)

CARE PERU

Sr James Becht, Director Adjunto de Programas

Dr Luis Tam, Gerente de Salud

Dr Ivan Velez, Coordinador Adjunto

Lic Gladis Soto, Directora Financiera

Lic Carmen Calvo, Contadora del Proyecto PF/CARE

ESAN

Dr Claudio Lanata, General Manager, Consorcio ESAN-PCMI

Dra Betsi Butron, Directora de Evaluación y Monitoreo

Dr Luis Gutierrez, Director of Community Component

JHU/CCP

Lic Patricia Poppe, Director for Latin America

Lic Max Tello, Representante Local

Lic Carla Quierolo, Consultora IEC

MOVIMIENTO MANUELA RAMOS

Sra Victoria Villavicencio, Coordinadora General
Sra Frescia Carrasco, Coordinadora P2000

AYACUCHO

Dr Roberto Aldoradin, Director General de la Director de Salud
Sr Julio Cordova, CIPRODES
Dr Lino Hinostroza, Directo del Hospital de Apoya Huamanga
Cost and Income Information System (SICI) Team
Budget Programming System (SPP) Team
Lic Enrique Mazuelos, Budget Preparation
Eco Moises Ramirez, Coordinator of Costs Unit

TRUJILLO

Dr Jaramillo, Director Regional
Lic Victoria Pinedo, IEC DIRES
Lic Celso Briceño, Consultor IEC
Lic Cesar Herrera, Consultor
Jany Aldave, Capacitacion
Lic Nadia Cano, Comision IEC
Lic Luisa Ancajima, Participacion Comunitaria
Lic Carmen Ruiz, Comision IEC
Prt Nelly Alfaro, Promotora de Ascope
Sra Susana Mendez, Madre de la comunidad
Sra Rosa Sanchez, IEC encargada
Dr Jeny Cosme, Jefe CC Ascope
Lic Lilia Rodriguez Hidalgo, Comision IEC
Ass Catalina Pasco, Comision IEC
Ass Elsa Rebaza Rodriguez, Comision IEC
Lic Cesar Herrera, Relaciones Publicas
Ass Cecilio Castillo, Comision IEC
Lic Cecilia Luna, Comision IEC
Ass Maria Tuestas, Comision IEC, Hospital Belen
Ass Elisa Rodriguez, Comision IEC Hospital Santa Isabel
Dr Rici Power, Comision IEC Hospital Santa Isabel
Obt Ivonne Manta Carillo, Comision IEC UTES No 1

SAN MARTIN

Dr Jose Paredes, Deputy Regional Director
Lic Elsa Cabrera, P2000 Coordinator
Sra Cecilia Palomino, Madre de la comunidad
Dr Augusto Llontop, Director of Human Resources
Dr Miguel Vela, Regional Director
Lic Quimisto del Aguila, IEC Unit
Lic Lily, Comision IEC
Lic Armando Vergara, Participacion Comunitaria
Lic Maria Elena Florez Ramirez, IEC Coordinator
Sra Magru Carbajal, Paciente Hospital Lamas
Sra Judith Carbajal, Madre de la Comunidad de Lamas

Sra Nelvith Ramirez, Madre de la comunidad de Lamas
Prt Hilaria Mego, Partera de la comunidad

LIMA ESTE

Dr Pablo Cordova, Director DIRE
Lic Lucio Huaman, Comision IEC
Lic Filomena Pedregal, Participacion Comunitaria
Lic Aldo Araujo, Comision IEC
Lic Jose Baca Carrillo,, Comision IEC
Dr Juan Carlos Yafac

PUNO

Dr Simon Checa Inofuente, Direccion Tecnica
Dr Elias Aycacha Manzaneda, Director del Hospital de Puno
Dr Jesus Gomez Pineda, Direccion de Salud de las Personas
Dr Pedro Valergo Gallegos, Coordinacion PAAG
CPC Hermenegildo Cortez, Direccion Ejecutiva de Administracion
Lic Isabel Mamai Illanes, Coordinacion Programa Materno Perinatal
Dr Edgar Cotacallapa, Coordinator Proyecto 2000
Lic Ubaldina Maldonado, Direccion de participacion Communitaria
Lic Clotilde Pinazo Calsin, Coord Prog Mujer Salud y Desarrollo
Ing German Tito Condori, Direccion de Estadistica e Informatica
Sra Amelia Bejar, Direccion de Planificacion y Presupuesto
Sr Gilberto Jaen B , Responsable de IEC
Sr Raul Miranda Arostigug, Regional Advisor EAT
Sr Daniel Eduardo Garanca, Assistant

ANNEX 4 BIBLIOGRAPHY

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ANNEX 5 SCHEDULE

Project 2000 Mid-term Evaluation Schedule

Sunday	Monday	Tuesday	Wednesday	Thursday
14 LKC, PT arrive	15 LKC, PT, JR meet with USAID, MINSA and IC	16 TPM	17 Interviews TPM Meetings	18 interviews
21 rest	22 Trujillo - LKC, PR, MJ, JR, HO, and LS Ayacucho - JF, MAB and MH	23 Trujillo - LKC, PR, MJ, JR, HO, and LS Ayacucho - JF, MAB and MH	24 Lima East - LKC, PR, JR and LS and maybe JF, MAB	25 Puno - NS, RC, LKC, PR, and LS Lima - JF and MH San Martin - JR, MC and MAB
28 rest	29 8-11 AM - Dr Oblitas 11-3 USAID	30 8 30 - 2 00 USAID 2 30 IC 4 30 USAID	31 interviews	1 holiday - writing
4 Easter	5 interviews	6 Debrief USAID IC	7 Debrief MoH Meetings at USAID	8 team departs
11	12	13	14	15 team sends materials to Laurie
18	19	20	21 USAID sends comments to team	22
25	26	27	28	29

ANNEX 6 FINANCE

6.1 EVALUATING THE FINANCING AND MANAGEMENT COMPONENTS OF PROJECT 2000

The purpose of this Annex is to provide a more detailed account of the analysis and reasoning that went into developing the observations, conclusions and recommendations provided in the **Section 8 Initiatives for Health Care Financing and Efficient Management** of the text. Although there is some overlap between the discussion presented here and in the text, several of the major discussions of the text are not addressed here. This Annex, therefore, should not be construed as a substitute for the text discussion, rather, it is a complement to that section.

A Antecedents

A.1 The Context and Rationale for the Design of the Financing Component

At the time that PROJECT 2000 was being designed, the MoH was in the throws of a severe recurrent cost crisis. The cost crisis was the result of a protracted and steady erosion in the Ministry's annual operating budget, which by 1992, had left it with a mere 36 percent of its 1982 real expenditure levels (see Fiedler 1993 for details). Financial constraints were clearly a salient, if not the single most important factor, limiting the Ministry's ability to provide adequate health care to Peruvians. It was, therefore, appropriate to include a financing component in the Project in order to attempt to address this severe problem.

A.2 The MoH's Current Financial Status: An Update

Starting in 1995, the Ministry of Health's long term cost crisis began to turn around. That year, the MoH received a marked increase in its budgetary allocation from MEF, enabling it to increase its 1995 expenditures to a level 2.4 times higher than those of 1994 (in nominal terms). This monumental increase in financing did not instantaneously end the many long-standing problems—financial and otherwise—of the MoH. After being starved of funds for more than a decade, it was necessary to begin a process of what amounted in many ways to the reconstruction of the Ministry. This is, perhaps, most dramatically demonstrated by the fact that the Ministry now could begin re-opening the hundreds of health facilities that had been closed, in some cases for many years, owing to financing shortfalls, terrorism, or some combination thereof.

Since the massive increase in the Ministry of Health's budget in 1995, its funding level remained relatively stable (in real terms) in 1996 and 1997. Last year, however, it fell substantially due to the economic recession and the shortfall of Central Government revenues, which the Government responded to by across-the-board cuts in spending of roughly 20 percent.

Since the design of P2000, officially reported (fiscalizado) user fees (ingresos propios) have continued to rise in importance, both in absolute terms and as a percent of total MoH revenues. They grew from nine percent of all MoH revenues in 1992 to 14 percent in 1998. In absolute terms, they grew from 12.7 million soles in 1991 to 213 million soles in 1998, an increase of 17-fold, in nominal terms. Since 1992, they have been increasing at a rate of about 50 percent per year (in nominal terms).

In short, the financial status of the MoH has improved significantly since 1992. As a result, the Project's Financing Component, while still important, has lost much of its urgency. It is no longer the *sine qua non* for improving the functioning and the quality of MoH care that it was when the Project was designed and the IC first contracted.

Growing MoH funding levels and growing user fee revenues are both reflective of the strong economic recovery that the Peru made in 1993-1997 from its severe depression of 1988-1992. The economy grew by 52 percent over the 1993-1997 period, but has since slowed. In 1998 it grew by only one percent and in 1999 it is expected to stagnate.

The growth in officially reported user fee revenues also is attributable to the 1994 MEF reform in the reporting and handling requirements for user fee revenues. Until then, MoH facilities were required to give their user fees to MEF, and they redounded to the public treasury.¹⁹ Thereafter, facilities were able to retain control over these revenues. This change in policy provided incentives for MoH facilities to collect user fees.

Propelled in part by the improvement in its financial status, the MoH's coverage of the national population increased from 16 percent to 25 percent, at the same time that the absolute size of the health care market was increasing (Petrera 1999). The MoH's provision of care increased from 8.0 million outpatient consultations in 1994 to 14.1 million in 1997 (Cuanto, 1995, 1998).

A 3 MEF and MoH Budget Reforms Performance- and Issue-Conditioning Considerations

MEF's National Budget Office has six distinct budgets for financing health services in Peru. The most important public health budgets (with nearly 90 percent of total health allocations in 1999) are the MINSA budget and the Ministry of the Presidency's (MIPRE's) allocations to the Transitory Regional Administrative Councils (CTARs). Up until 1990, the MINSA budget covered all MoH activities, incorporating both the present-day MINSA budget and the MIPRE-managed CTAR health allocations. Since 1990, the Regions' MoH budget has been separated out and each region/subregion is assigned its own budget. The MINSA budget continues to include the financing of Lima/Callao and the three vertical, national priority programs, Basic Health for All (PSBPT), Family Planning and the Complementary Food Program. MEF's 1999 initial total MoH allocation was 2.6 billion soles, comprised of a 1.0 billion soles allocation (38 percent) to the MoH MIPRE account, and 1.6 billion soles (62 percent) to the MINSA account.

In 1996, MEF announced a major budget reform package. Law Number 26703, Law of Budgetary Management of the State, provided the legal foundation for the changes and set forth the reform agenda. MEF initiated the implementation of the reform in 1997. In terms of their impact on the MoH, the key elements of the package included:

- The establishment of a new budget structure, which has not since been modified, thereby providing stability of budgetary categories. Compared to the pre-reform era, when budgetary categories changed significantly from year to year, this makes it much easier to analyze and manage the budget.

¹⁹ The turning in of user fees was on paper only, the MEF registered fees and reported them but none were collected.

- Promotion of the development and use by all government agencies of cost-based budgeting systems, tied to quantified goals and outputs
- Increased flexibility, discretion and responsibilities were given to Ministries. It is now the responsibility of the MoH to decide how it will use the budget it receives, rather than being told how it will spend its budget. This increases the autonomy of the MoH.
- Similarly, the Regions/Departments now have the responsibility of deciding how much to spend on health and how to spend it (beyond the requirement that they pay the *planilla*, which requires roughly 70% of total revenues). This increases the autonomy of the CTARs and constitutes decentralization.
- The development of a software package that is provided to state entities (containing relevant portions of the SIAF) which are required to use it to submit their budget requests and to report expenditures.
- Monthly budgeting of expenditure (10 days before start of each quarter) with quarterly disbursements (tranches) 20 days before the start of each quarter.

As will be seen below, these reforms directly addressed some of the key issues identified in the P2000 contract as potential policy dialogue topics, and made possible new means and avenues for addressing other structural problems of the MoH.

B The Slow Start of the P2000 Financing and Management Component Activities

Both the Management and the Financing Components got off to a slow start, especially considering that the person put in charge of them, the Health Economist, was originally funded for only four years (through February 1999). Factors contributing to this slow start included

- the disparate nature of various activities, which was exacerbated in the Financing component by the absence of a ranking of relative priorities (in contrast, the management component unambiguously identified the Budget Programming System at the top priority),
- the fact that the financing component had several activities which were to be implemented on a national scale, while the rest of the project operated on only a sub-national level, caused considerable confusion,
- the relatively limited resources available for these components, given the complexity of some of the activities, the long time period it would take to effectively implement and institutionalize them, and the nationwide scope of several of them,
- the lack of clarity and definition by MoH senior management, exacerbated by frequent changes of top personnel (including the Minister), and
- the lack of a national counterpart agency or individual, which made getting the MoH "on board" a more involved and time-consuming process, and frequently resulted in the health economist being relied upon as a MoH staff-person (heading up first the Inter-Institutional Coordinating Committee's Health Financing Subcommittee and later the Ministry's Health Care Financing Committee), thereby reducing the time available for project activities.

C The Demand, Cost and Other Early Studies

Another reason for the slow start of the Financing and Management Components was that the demand and cost studies which were to provide input into the design of the national user fee system, were to be completed, reviewed by the MoH and AID and "made available for use by the IC soon after the Contract is initiated," were not completed until May 1996, 16 months into the Project

The cost study was well done. The methodology it developed and employed became the standard approach adopted in several important subsequent studies. In addition, it became the foundation of the Cost and Income Information System (Sistema Informatica de Costos y Ingresos, SICI) and is used to develop the health care services cost estimates which are an essential element in the Budget Programming System (Sistema de Programacion Presupuestaria, SPP). As such, the cost study has had an impact on health policy.

The demand study was less successful, in part due to financial constraints and in part to technical decisions. The demand study had been designed to provide the requisite information with which to design a national MoH user fee system. It proved less than satisfactory for that purpose. As originally designed, the demand study was to have been based on a probability sample consisting of nine geographically defined strata: Lima Metropolitan, the urban costa, the rural costa, the urban sierra, the rural sierra, the urban high selva, the rural high selva, the urban low selva and the rural low selva. Also, it was to have produced two distinct reports:

The first will be a report discussing the general findings, and will also analyze differences in the coverage and utilization rates of each of the subsectors and by geographic area. The second study will be an econometric analysis of the demand for services. Separate estimates of the own-price, cross-price and income-elasticities of demand will be computed for (at minimum) each of the four distinct geographic stratum, viz, the Lima Metropolitan Area, the rest of the costa, the sierra and the selva. Finally, assuming several different changes in the level of MoH prices the impact of those changes on the quantity of MoH services demanded and the level of MoH user fee revenues should be simulated (Fiedler, 1993, p. V-14).

The econometric model, however, was improperly specified. Rather than the survey data being used as a tool for market analysis and market identification, it was simply assumed that the entire country could be regarded as a single market.

Several studies that were not identified in the P2000 contract were done early on in the project at the insistence of the MoH. The Ministry maintained that these works were essential to providing a comprehensive understanding of the health care system and health care financing, which it felt was indispensable before intelligent talk about health care financing and management reform could begin. These studies included:

- “Analysis of Public Health Spending,” MACROCONSULT (10/95-4/96)
- “Evaluation of the Procedures of Programming and Budgeting of the Regions and Sub-regions of Health,” MACROCONSULT (10/95-4/96)

The nature of these two studies—fundamental analytic pieces about MoH financing and public health care expenditures—reflect the MoH’s lack of health care financing and health policy analysts. In essence, with respect to these studies and in other activities, as well, the MoH relied on P2000 to perform what should be standard staff functions.

These works, and particularly the cost and demand studies, were among the first studies of this type in Peru in more than a decade. They filled an important information void, and are regarded by many as important, pioneering, reference works. Moreover, they are credited with providing the initial impetus for conducting analytic studies of health care financing, which subsequently have become more common. A recent document of the Inter-American Development Bank’s Strengthening Health Care Services Project noted, these were “significant studies that laid an important and analytically strong foundation for understanding the health care market and for planning MoH activities in Peru,” (IDB, 1998). The studies also brought attention, credibility and respect to P2000’s efforts in the areas of financing and management, and laid the groundwork for the very considerable coordination and leveraging that the Project has achieved.

D Development of a National User Fee System

The P2000 SOW financing and management activities include (1) the development of an inventory of existing cost-recovery and efficiency enhancing schemes and (2) the selection of the most promising such schemes to (a) case study and (b) undertake operations research on them to improve their performance. These activities were to have provided models for the component parts of user fee systems (viz, exemption policies and mechanisms, and administrative systems), that were to be combined with the econometric results of the demand study to identify the level and structure of fees. Both of these activities—the outputs from which also were intended to provide input into the design of that system—have only recently been started in earnest. Thus, despite the fact that the demand study did not provide the type of data envisaged—a foundation upon which to build a national user fee system—it did not constitute a critical obstacle to the development of such a system.

A number of considerations suggest that P2000 has higher priorities at this time and that completion of these two activities should be dropped (although currently contracted work should be completed)

- presidential elections are only a year away, and there is no reasonable hope of establishing a national user fee system until some months after a newly elected administration has taken office,
- much of the type of information that was to have been obtained from these activities is now available from a number of recently completed studies, including
 - a forthcoming Pan-American Health Organization (PAHO) sponsored study of user fees based on a nationwide sample of 83 MoH facilities,

- a DFID-sponsored study in Arequipa and San Martin of user fees in health centers and posts,
- the two studies by Margarita Petrera (of PAHO), "La Demanda por Servicios de Salud de la Mujer Rural en el Peru," 1998, and "Aseguramiento Publico en Salud Factores que Intervienen en la Eleccion de Proveedor," (borrador), Marzo de 1999
- information from the P2000-designed SICI for eight hospitals and four networks of facilities will be available by mid-2000,
- the World Bank-financed Basic Health and Nutrition (PSNB) Project is in the process of contracting Management Sciences for Health (MSH) to devise a Monitoring, Training and Planning (MTP) module on user fees, the design and implementation of which (tentatively scheduled for 2000) will generate much of this same information,
- P2000's own already-completed studies GRADE 1998 and Cortez 1999
- Most importantly, the Health Economist needs to focus her attention and project resources on the SPP to better ensure that it is fully institutionalized and sustainable

The recommendation to drop further work on user fees should not be construed as suggesting that user fees are no longer an important MoH issue in Peru. They are very important. User fee revenues grew from nine percent of all MoH revenues in 1992 to 15 percent in 1998. In absolute terms they grew from 12.7 million soles in 1991 to 213 million soles in 1998, a 17-fold increase (in nominal terms). Moreover, there is evidence that they constitute an important barrier to access to care (Petrera 1998). The MoH system is characterized by a plethora of idiosyncratic, facility-specific user fee systems that have come to constitute a barrier to access to care. Of the one-fifth of Peruvians who reported they were ill in the past four weeks and felt they needed to obtain health care but did not do so, 76% reported that they did not seek care because they could not afford it, i.e., 15% of persons who felt they needed care were deterred by economic considerations (Petrera 1999). User fees are important, but for the reasons already noted, P2000 should focus on other issues. However, to the extent that P2000 is investigating user fee systems, it must strive to make a contribution to the current debate. The GRADE contract to design, set up, implement and evaluate user fees in two departments, falls short of that goal. Annex 1.1 contains a review of GRADE's March 1999 report and some suggestions for modifying the GRADE contract.

E Policy Dialogue

A condition precedent for USAID's awarding P2000 was for the Government of Peru to establish the Inter-institutional Coordinating Committee (ICC). The ICC was seen as a potentially important vehicle for coordinating major health sector actors, while providing a forum for policy dialogue. The ICC was formed when P2000 started, but met only three times and was never an effective tool of policy dialogue. Subsequently, another committee was formed that was charged with addressing health care financing issues. This was the Financing Committee, formed by MINSA in mid-1995. Due to the dearth of health care financing expertise in the Ministry, the P2000 Health Economist was the chair/coordinator of this committee from its inception until October 1998, when she stepped down. Since then, the coordinator position has been assumed by the PSNB, and the Committee has not met.

Shortly after the initiation of P2000, when the introduction of a national user fee system looked politically feasible, the Inter-American Development Bank-funded Strengthening Health Services (PFSS) Project insisted (in ICC meetings) on taking the lead in the design of the system. PFSS never produced a report or recommendations on user fees. The topic also fell out of favor within the Ministry for a time. The topic of user fees got lost in the new current of major health sector reform, particularly as the idea of introducing universal insurance came to be debated. User fees were not considered reform, and they were not a priority. These developments discouraged the Project from undertaking much work in the area of user fees. By the time the current Minister came to power and user fees were again an accepted topic for discussion, the user fee system-related activities of other agencies and the distraction of other activities and interests have, for the most part, kept P2000 from returning to the topic, although not entirely. It has incorporated user fee revenues and expenditures of own income (*ingresos propios*) in recent changes it has introduced in the SPP and SICI. Also, P2000 has conducted a demand study (Cortez 1999) of Huaras, and has contracted GRADE to develop and assess user fee systems in two departments.

In assessing P2000's policy dialogue efforts it is important to recognize that a number of the topics which the contract identified as important, potential issues for policy dialogue, have already been addressed, are no longer relevant, or are being addressed by P2000 in other ways, such as

- "Development of processes for programming, budgeting and accounting. These should move to a cost-based budgeting system that more directly support GOP health priorities." The SPP and SICI are addressing this issue.
- "Reunification of the entire MoH budget, which is currently segmented into Lima/Callao and the rest of the country. The present practice is conducive to urban bias." MEF did so, but only temporarily in the spring of 1998. The share of the regions has increased slowly, but steadily from 31 percent of the MINSA plus MIPRE/CTAR health budgets in 1991 to 38 percent in 1999.
- "Discussion of the HIS system can play a more dynamic and influential role in making decisions about health policies and programs." PCMI is introducing a data-driven approach to decision-making, although the database it uses is the SIP.

Some of these changes are the result of MEF budget development and monitoring reforms (discussed earlier). Others are due to changes in the way in which the MoH allocates resources. See the tables at the end of this ANNEX. For instance, Table A 1.1 shows that MINSA's Basic Health for All Program (PSBPT) allocates

- 16 percent more money per person to the seven "very poor" departments than it does to the seven "poor" departments,
- 16 percent more capita to its "poor" than to the nine "regular" departments,
- 39 percent more to its "regular" departments than to Lima/Callao.

In short, the PSBPT allocates more money to the poorer portions of the country and less to the wealthier. The "very poor" departments receive 88 percent more per capita than does Lima/Callao from PSBPT program.

The Complementary Food Program (PACFO) also uses "need/poverty" based criteria to allocate resources. Although the PAC's allocation pattern is not directly (linearly) related to departments' poverty category, as is the PSBPT, its impact is even more highly redistributive. Whereas 29 percent of the

PSBPT's total budget is allocated to the seven "very poor" departments, these departments receive twice as large a share, 60 percent, of the PAC's total budget. These redistributive resource allocation patterns reflect the introduction of new programs that are targeted to the poor, and manifest important changes in the way in which the MoH has traditionally allocated resources. Overall, however, Lima/Callao continues to get the lion's share, 62 percent, of total MoH resources (i.e., MINSA plus MIPRE's Regional/CTAR Health) (Table A 1.1).

While the MINSA has been adopting new approaches to financing that enhance equity, the same cannot be said of that portion of the MoH budget that is allocated by MIPRE. As Table A 1.6 in Annex 1.2 shows, the distribution pattern of the regional health budgets by department income category did not change between 1993 and 1999: in both years, the share of the "very poor" was 26 percent, that of the "poor" was 35 percent, and the "regular" departments received 39 percent. The MIPRE resource allocation takes into account consideration of own-resources (*ingresos propios*) that are to be generated by each department. As may be seen in Table A 1.3, the level of own resources that MIPRE assumes will be forthcoming are based on historical patterns of reported actual, resource generation from user fees. As is evident in Table A 1.7, the amounts of own-resource generation that are assumed will be forthcoming in departments vary dramatically in both absolute and relative (as a proportion of total regional budget) terms. For instance, the "very poor" departments of Cusco, Pasco and Cajamarca are expected to generate 24, 22 and 22 percent (respectively) of their total regional resources from own income, compared to only 13, 16 and 15 percent in the "regular" departments of Moquegua, Tumbes and Tacna. The poorest departments are expected to pay for more of their health care than are the "regular" income departments. This is inequitable. If there is to be greater equity in the distribution of MoH resources, not all of the change can be expected to come from the 62 percent of the budget that the MINSA Central Office controls: there also must be reform in the way in which MIPRE allocates health resources. This is an issue that should be discussed by an Inter-institutional Coordinating Committee.

There are other important issues that also need to be discussed in such a forum. For instance, there remains a need for public debate on the objectives of a national user fee system, and there is a need for a continued coordination of the international agencies working in health. The growing coincidence of interests and activities and the recent launching of the design phase of new IDB and World Bank projects (both of which will be building on the work of P2000), make coordination essential. While the Ministry's Health Financing Committee can play an important information sharing and coordination role, the MoH needs to work more closely with MEF and MIPRE (which controls the health budget allocations made to the Regions/Departments), and develop a permanent forum for doing so. It is, therefore, recommended that an inter-institutional committee, similar to the ICC, be constituted. Other potential issues to be addressed by this committee, include:

- the development of uniform public health policies and objectives by which to allocate the public health resources of both MINSA and MIPRE/CTARs,
- the development of uniform MINSA and MIPRE/CTAR administrative systems for the SPP and user fees,
- develop and implement strategies and methods for targeting resources, including new resource allocation criteria used alone or in conjunction with user fee exoneration policies to target resources to the poor, and
- developing criteria by which to assess the Maternal-Child Insurance and Student Insurance Programs, and jointly sponsor evaluations of these programs

F The Budget Programming System (SPP)

The Budget Programming System is undoubtedly the most significant output of the Financing and Management Components of P2000. The three and a half year, half a million dollar investment in the development and partial implementation of the SPP has produced a powerful, flexible tool for developing health service delivery goal-based estimates of financing requirements.

The SPP is an electronic spreadsheet-based software program that can be used to estimate both the unit costs and the total costs of all MINSA health facility activities, including

- final services (such as particular types of outpatient consultations, e.g., a prenatal care visit),
- intermediate services (such as laundry services, x-rays or laboratory examinations) and
- administrative services (such as filling out reporting forms, paying bills, and accounting).

The first step in using the system consists of the user quantifying specific output goals for the coming year. In addition, the user must identify the types, quantities and prices of the inputs required to produce one of each of the identified service goals (e.g., the time of a nurse, a syringe, a cotton swab, alcohol and measles antigen to provide a measles vaccination).

The SPP is very flexible. It can be used in hospitals, health centers or health posts. It can be used to estimate the financing requirements of an individual facility, a network of facilities, a regional/subregional health system (SRS or DIRES) or the entire MINSA system. While it is set up to program a year, it can be used to program any length of time. It also can be used to program the budget from any number of distinct financing sources, such as MINSA transfers of public treasury/ordinary resources from the Basic Health for All Program, the Family Planning Program, or the Complementary Food Program, as well as CTAR funds and user fee-generated revenues (*ingresos propios*). This is an important feature as not all of the resources from these distinct sources are entirely fungible (i.e., they are, to varying degrees, earmarked for specific purposes).

This system represents an important break with the way MINSA has established goals and developed budget requests in the past. Until the introduction of this system, most service delivery goals were generally established by each vertical program's national office, with non-vertical program service goals generally set by regional office personnel. The SPP is a tool for turning this top-down approach on its head: specific service delivery goals are established at the local level (either the facility, the facility network or the DIRES, depending upon exactly how it is implemented). MINSA budget requests used to be simply extrapolations of the previous year's budget, and generally did not reflect either anticipated service delivery levels or the costs of providing care. The SPP is a vehicle for linking inputs, costs and outputs. It makes available for the first time information which is necessary, but not sufficient, for improving the managerial performance of MoH personnel and facilities.

By providing a vehicle for expressing locally felt needs and priorities, and replacing the former top-down with a bottom-up approach, the SPP may be seen as an important tool for effective decentralization and empowering local MoH personnel. As such, like the PCMI system, it too provides impetus to democracy-nurturing types of changes in the traditional mode of functioning of the State, and specifically the MoH. The significance of the development and successful implementation of the SPP cannot be overstated: it ushers in a new era in the MoH.

The SPP, however, is not yet implemented. In 1998, with assistance of the PSNB and the Pan-American Health Organization (PAHO), P2000 hosted SPP training and pilot-testing in the 12 P2000 DIRES, the Callao DIRES and the eight sub-regions (networks) of the PSNB. Management Sciences for Health's (MSH's) Management Training and Planning (MCP) approach, which has just started to be implemented, looks well designed and as if it will be an important tool for helping to institutionalize the system. Nevertheless, the pilot-testing experiences and the feedback provided at a November 1998 national workshop of DIRES personnel and a March 1999 "SPP validation" workshop, suggest that it would be advisable to go a bit more slowly (MINSA, P2000 & PSNB, 1998).

The MoH's General Office of Planning (OGP) has officially adopted the SPP as the tool that it will use to develop budget requirement estimates that it annually submits to MEF. The MoH plans to use the SPP to develop the annual DIRES-level budget estimates for next year, 2000, but will be hard-pressed to achieve this goal. This goal underscores the overly optimistic view of implementing the SPP, which needs to be reassessed. The training and implementation phases of the SPP are critical and should not be short-changed. Doing so will put the institutionalization of this important innovation at-risk and will unnecessarily jeopardize the investment that has been made in its development to date.

If the SPP has a shortcoming, it may be that the system is too comprehensive and too complex to implement throughout the country in a single step, as is currently planned. The system consists of more than 30 files, has 80 different categories of personnel, 100 components and 290 sub-components, for each of which the user has to collect and enter data. While it is a user-friendly system, it is still a monumental task that is likely to be daunting to some, and of sustainable, practical use for others only if it is phased-in over several years.

One cannot but question whether the training and implementation plan that has been developed (in conjunction with the PSNB that is co-financing this phase of the activity) is adequate. That plan consists of a series of national and regional/departmental level workshops. Each agency to be trained in implementing will receive a total of four days of training in the critical Modules 1 and 2, with Modules 3 and 4 being the responsibility of the OGP. The training system includes a self-instruction CD, a manual and an introduction to a modularized group-work. The CD and MSH's MTP are novel approaches, and look promising. Still, the magnitude of the change being introduced and the data requirements suggest that this plan is inadequate, and two recent feedback and planning sessions underscore this concern.

The first of these sessions was a workshop held on November 5 and 6, 1998, hosted by P2000 and the PSNB, to which representatives of all 24 department's regional office directorates (DIRES) were invited to discuss the SPP and user fee issues. The meeting was dubbed "Technical Meeting Initiatives for Improving Financial Management." Twenty-one departments were represented. The meeting was attended by the directors, assistant directors and chiefs of the Offices of Planning and Budget of the DIRES. The meeting was structured, with one day dedicated to SPP issues and one day dedicated to user fee issues. The SPP discussion was structured around the following themes:

- perceptions of the SPP as a management tool,
- identifying key ways to strengthen and reinforce the SPP,
- weaknesses of the SPP, and
- opinions about proposed training plan

The second day's user fee discussion was structured around the following issues:

- levels of knowledge about measuring and evaluating equity, efficiency and targeting strategies,
- identifying priorities within both areas: user fees and targeting,

- the division of labor / assignment of responsibility for particular components of user fee and targeting policies,
- limitations to applying a targeting strategy, and
- required actions for overcoming identified limitations

Among the major findings and conclusions of this meeting

The second of the SPP evaluation and planning sessions was what was labeled a meeting for “validating” the SPP. The attendees were persons who are probably the most sophisticated of the soon-to-be users of the SPP, personnel from the Lima/Callao DIRES’ Budget Teams. Yet they could not get beyond the conceptualization stage and their concerns and questions about methodology. It wasn’t planned this way, but the meeting was continued two days later. Why should we think it will be any different with a less well-prepared group of people? The training and implementation phases of the SPP are critical and should not be short-changed. Doing an inadequate job on this phase of the activity, risks squandering this opportunity and the resources that have already invested in this activity over the past three years. This is a gamble that should not be taken.

The OGP, P2000, PSNB and PAHO have drafted an “SPP institutionalization agreement” for signature. Although this document identifies next steps and who is responsible for what, it does not identify specific required inputs (equipment, training, new position descriptions, additional personnel, etc.), nor does it have a timeline or deadlines for specific activities. Too much depends on not following-up closely with the OGP in more carefully delineating the specifics of this document, in assisting it in implementing Modules 3 and 4 and in providing adequate time for further evaluation and follow-up.

It may be necessary to develop a simplified version of the system that could be initially implemented in locales with inadequate administrative capacity. The current, more full-blown model then could be introduced over a period of several years. It is recommended that additional resources be dedicated to the training, implementation, evaluation and follow-up of the SPP. This would allow for additional facility-level, regional and national implementation feedback, evaluation and planning workshops of the types conducted by P2000 in November 1998 and March 1999 already discussed. It also would allow time for investigating other means by which to simplify the basic model and, to the extent deemed necessary, devising phase-in packages of the SPP.

One way in which the basic model could be modified that should be investigated would be to develop and use treatment protocol norms in estimating the costs of both personnel and supplies inputs and costs. This would serve three purposes:

- First, it would greatly facilitate the annual development of the resource requirements/costs of producing the stated goals and service delivery targets. Rather than having to work with each employee in the sample of facilities to be costed each year to develop an estimate of his/her time devoted to each type of activity, treatment protocols would provide a standardized input/output type of relationship for each activity, thereby obviating the need for this very time-consuming undertaking.
- Second, it would base the cost of service provision on *all* of the inputs required in *all* facilities and DIRES, and would make these estimates independent of the idiosyncratic practices which have developed over the past 20 years, whereby the provision of some of the drugs and other medical supplies, and thus some of the costs of providing these services, have come to be the responsibility of the patient. These practices have become institutionalized in the host of idiosyncratic *modus operandi* of facilities, and result in potentially large deviations in different facilities’ and DIRES’ estimates of the cost of providing different types of services. Reliance on treatment protocols to

define input requirements would standardize the approach to costing and thereby would serve to make the application of the SPP more equitable

- Third, employing standardized treatment protocols would enable more readily identifying and analyzing variations in labor productivity and labor/facility capacity utilization. For instance, rather than simply finding that fewer services are provided in particular facilities or DIREs, it would be possible to estimate the amount of what might either be (a) down-time, i.e., time that is not spent on direct service delivery or administrative activities (and is available for increasing the provision of consultations or other services delivery) or (b) excess time spent providing some services, and to determine which of these two characterizations more accurately describes the particular situation. This capability provides information with important management implications.

The SPP does not yet have a budget execution evaluation module, although one is discussed in CIPRODES and MSH P2000 documents. To facilitate and encourage the use of the SPP in management and budget allocation decision-making, this module should be developed and included in the basic software package.

Finally, it should be recognized that fulfilling the P2000 terms of reference (TOR) required only that a national cost-based budgeting system be developed and implemented. It did not require the development and implementation of the much more decentralized SPP system that has been developed. The way in which Project 2000 has defined and undertaken this activity is a significantly more ambitious task. The MEF's reforms have made the development of the SPP for application at below the national level an invaluable one. This is an important modification that has required far more preparatory work and more resources than had been envisaged in the original contract. P2000 has gone well beyond its TOR to adapt to the evolving conditions in Peru and has fulfilled the more demanding requirements that MEF has made of the MoH since the design of the Project.

By the same token, however, the timing of "Law Number 26703 Law of Budgetary Management of the State" and the budget reforms MEF introduced in 1997 to comply with this new law were propitious for P2000. The passage of this law encouraged the OGP to become interested in and to adopt the SPP as a means by which it could comply with both the spirit and the letter of the MEF's new approach. This is not to suggest that the OGP might not have done so anyway. However, the slow speed with which the OGP became familiar with the SPP system suggests that, at the very least, MEF's new mandate to State agencies served to expedite OGP's adoption of the SPP.

G Issues and Considerations in Estimating the Costs of PCMI

The assessment of the financial sustainability of a project usually begins with an analysis of its cost. In this analysis it is critical to distinguish between what are termed "start-up" costs and what are labeled "recurrent" costs. As the name suggests, start-up costs are those costs that are incurred undertaking activities which are essential to starting a new project or activity, and are generally one-time in nature. In contrast, recurrent costs are costs that are incurred each year in the course of undertaking activities that must be on going in order to maintain the program or intervention. The focus of financial sustainability assessments is on recurrent costs. If the recurrent costs of the project can be absorbed (in this instance, by the MoH) the project is regarded as financially sustainable.

The PCMI component of P2000, however, does not readily lend itself to this standard approach because (1) it is experimental, and is being pilot-tested and modified as it is being implemented, and (2) due to the inherent difficulties of defining a standardized set of activities in an intervention which is, by design, a decentralized, empirically-driven, needs-based intervention. These characteristics of the PCMI intervention blur the distinction between start-up and recurrent activities, and thereby between start-up

and recurrent costs, and, together with the lack of project documentation and the limited time available, preclude estimating the costs of the PCMI program during this evaluation

G 1 The Inherent Difficulty of Estimating the Costs of PCMI

It is imperative to note that the costs of PCMI are not only the costs that are incurred by P2000 PCMI also requires other inputs, many of which provided in-kind by the MoH Most importantly are the time costs of the many staff persons who participate in PCMI training and implementation As PCMI training and implementation cascades down to the local level, it becomes increasingly difficult to determine exactly where the implementation of the model ends and every-day work begins the implementation of this on-the-job problem-identification and problem-solving approach at some point becomes indistinguishable from everyday work

Nevertheless, it becomes important to delineate where and when PCMI implementation ends, if we are to cost the implementation of the model No effort has been made to assess this cost or its sustainability, but clearly it is an important one when we consider training most of the MoH's 70,000 employees This cost is particularly important to quantify because it is at the end of the PCMI implementation cascade that the largest numbers of persons are involved At the same time, however, it is this cost that is particularly difficult to quantify because as the PCMI intervention cascades down to the local level it becomes increasingly idiosyncratic and ultimately individual facility- and even individual staff-specific The PCMI model is based on trainee-identified problems and trainee-identified methods by which to address those problems Thus beyond the skeletal, three-tiered, structure of the model (national training of trainers, regional training, local level training), the costs of the program at the periphery are a function of the exact nature of training—training topics, training sites, training topics, number of trainees, number of sessions—which is a training application-specific outcome of local level discussions and decisions

The general magnitude of these costs suggests that the financial sustainability of these costs--and concomitantly of PCMI--will be largely determined by the outcome of two countervailing factors, viz , the frequency with which the PCMI training occurs and the increases in productivity and quality of care which are directly attributable to PCMI Both of these factors are exceedingly difficult to quantify (due to confounding factors)

G 2 Supervision and Training Long Term Cost and Sustainability

The nature of PCMI is such that it obviates the need for a great deal of traditional supervision and training Assessing the longer-term financial sustainability of PCMI requires reconfiguring traditional supervisory and training systems to take full advantage of PCMI Considerable cost savings are likely to be realized as a result of doing so

The costs of supervision and training are currently higher than they need be and are likely to be once the complete model is defined At that point, both the MoH's current supervisory and training systems, which are both traditional in nature, together with the model's supervisory and training systems are both being maintained Once the model is fully articulated, traditional supervisory and training activities can be revised and integrated into the model, thereby reducing total supervisory and training costs In light of the fact that both systems are currently in operation, and the final configuration of supervision and training systems is still uncertain, the long term (i e , post-start-up) costs of the PCMI are difficult to estimate

G 3 A Costing Methodology that Should Not be Adopted

USAID has required the contractors and sub-contractors of P2000 to submit their invoices using a system that relates all costs to specific outputs identified in the Project's TOR. This system for reporting expenditures by project component is internal to USAID that has been adopted to provide better control over annual expenditures than the traditional approach of annual budgets. At first glance, it might appear that this system provides the cost estimates of each Project activity, and that, therefore, there is no need for undertaking a costing exercise: the required information is already available, or with a modicum of effort, combining different activities could readily be in hand. That, however, is not the case. First, as already noted many of the activities undertaken to date have involved false starts, activities that have been abandoned for various reasons, or have constituted what should be regarded as start-up costs, and thus overstate the cost of the activities. Second, and more fundamentally, while this method of costing activities may serve USAID purposes, from the perspective of the contractors, it cannot but be regarded as an artificial construct that may result in cost estimates that seriously deviate from a given activity's actual costs. Why is this? This system requires that an activity be completed before an invoice for it can be submitted. However, some activities may take a very long time to complete. If a contractor is working on a particular activity for several months and it is an expensive undertaking, the contractor is likely to find it necessary to bill for some portion of the costs of the activity in order to pay bills and ease cash flow. How does the contractor do so? By increasing the cost of activities that have been completed and for which it can submit an invoice. It should be evident that how an "activity" is defined—whether in terms of some all-encompassing end product, or in terms of a series of intermediate products—is critical. But what happens when intermediate products are not (and perhaps could not have been) anticipated, for instance, because they are the outcome of negotiations between different involved parties? The result is that some activities (particularly those with a long gestation period, those subject to negotiation, and those defined "too" grossly in terms of only final products) are likely to appear to be far less costly than they were in fact. Conversely, some activities (particularly those that are recurrent, or have short gestation period or duration) are likely to appear to be more costly than really they are. Therefore, while this system may be a useful starting point for devising a methodology for estimating the cost of P2000 activities (by, e.g., identifying cost centers), it should not be construed as providing accurate estimates of the cost of P2000 activities.

6.2 Suggested Modifications to the GRADE Contract

The GRADE contract to set up and assess two pilot user fee systems should be modified: the contract should be extended for an additional six months to provide more time for the system(s) to be established and up-and-running before it is assessed. Also, the user fee administrative systems—including the role of the DIRES in monitoring—must be made a primary focus of the study. The proposed public discussion of the objectives of a national user fee system (in an "Inter-campus-type event") should be postponed until early 2001.

Comments on GRADE (Grupo de Analisis para el Desarrollo), "Sistema de Tarifas y Exoneraciones de los Servicios del Ministerio de Salud. Propuesta General del Sistema de Tarifas y Exoneraciones por los Servicios que Ofrecen los Establecimientos de Salud del MINSA," Marzo 1999.

This is not a general proposal, as it is entitled. The piece is far too theoretical, too academic. It consists of five components: An analytic framework, a simulation model, a review of international literature on demand, a review of international literature on exonerations and targeting, and a review of exonerations systems in two Peruvian institutions. These are all presented as individual chapters and never integrated. It looks like five different individuals wrote the chapters. What's the purpose of doing the literature reviews if they're not going to be used to in the design of the system? Is this just mechanistic completion of terms of reference? The analytic framework/simulation model developed is sophisticated, but what is

its practical application? What is it GRADE is proposing to do? Are they not going to design, implement and assess user fee systems in these two departments? Have they even visited Taca or Huaraz? Do they plan to?

What is needed is a diagnosis of the current systems, an observational review of what the different MINSA facilities in these two departments are currently doing. It is arrogant and presumptuous of GRADE to think that it is going to design a system and install it without any understanding of local conditions. These facilities have had user fee systems for 20 years or more. What have they constructed? What are its strengths and weaknesses? Yes, price levels and the structure of prices are important, but the focus needs to be administrative systems. The GRADE report only has prices for one hospital in the area and it assumes some price levels for a health center and dismisses the rest of the facilities in the area as having few revenues. That is not good enough. The GRADE report has some utilization/service delivery data for these two facilities. That is not good enough, either.

At one point the report notes that administrative costs and administrative capacity are important factors in the design and operation of user fee systems, but the report never addresses these issues? How are they going to devise such a system without visiting these places and assessing administrative capacity and administrative systems?

There are some other difficult issues that need addressing, as well. Historically, the major reason user fee systems have developed has been the shortages of supplies. MINSA facilities started charging in order to be able to purchase supplies so that they could do their work—provide health care. From ENNIV data, it looks like there is a need to reduce the economic barrier to access to care—specifically to reduce the prices being charged indigents. That is going to mean exempting more poor people than are currently exempted in many places. How can user fee systems be structured or combined with other financing tools to encourage MINSA personnel to exempt people—to encourage them to give up some of their user fee revenues?

Another important issue that needs to be addressed is what to do about corruption and the embezzling of user fee revenues? What can be done--both within the facility and beyond the facility--to discourage these leakages? Within the facility, this may mean redesigning how patients move through the system (patient flow) and when and where patient pay for their care. What about tracking revenues within the facility? A method must be developed whereby "sales receipts" for services can be combined with service delivery data to crosscheck revenues and exemptions/exonerations. Putting a committee in charge of reviewing this data periodically (e.g., once a week) is a good way of discouraging leakages. And what should be the role of the DIRES in monitoring and maintaining the integrity of the system?

There are some legal issues that need to be addressed, as well. There is at least one CTAR that now claims 10% of the user fee revenues from the MINSA facilities in its area. Is that legal? Is that desirable? Can or should the CTAR get involved in doing some type of monitoring of the fees? Should that be instead of the DIRES?

It would be useful to discuss how to go about developing identification cards for indigents to minimize the administrative costs of the system. What are the pros and cons of such a system? How frequently should such cards be updated? Once every year? That is probably too often, given utilization rates. Once every two or three years?

6.3 Changes in MINSA's Resource Allocation (Tables only)

Table A 1 1								
MINSA 1999 BUDGET ALLOCATIONS BY DEPARTMENT								
Including the MIPRE Regional Allocations Plus the MINSA Allocations								
	MINSA Transfers							
Department	Basic Health for All	Family Planning	Complemen tary Food	Total MINSA Transfer	Regional Budget	General Total	MINSA as % Total	Popula- tion (000)
A Muy Pobre	89 591,399	4,937,421	76 735,048	171 263 868	178,912 400	350,176 268	49%	5,015
B Pobre	89,617 591	7 424,950	3,481,814	100,524,355	244 218 011	344,742 366	29%	5 826
C Regular	62 008,248	5 685,432	2 378 667	70 072 347	275,738 291	345 810 638	20%	4 671
Sub-Total (= A + B + C)	241 217,238	18,047,803	82 595 529	341,860 570	698,868,702	1 040 729 272	33%	15 512
Acceptable	67,885,724	20 154,320	46,242,471	134 282,515	1,535 366 752	1 669,649,267	8%	7,127
TOTAL	309,102,962	38 202 123	128,838 000	476,143,085	2 234 235 454	2,710,378 539	18%	22,639
Lima / Callao %	22%	53%	36%	28%	69%	62%		31%

Table A 1 2						
MINSA 1999 PER CAPITA BUDGET ALLOCATIONS BY DEPARTMENT						
Including the MIPRE Regional Allocations Plus the MINSA Allocations						
	MINSA TRANSFERS					
	Basic Health	Family	Complemen-	Total MINSA	Regional	General
Department	for All	Planning	tary Food	Transfer	Budget	Total
A Muy Pobre	17,865	985	15 301	34,150	35,675	69,826
B Pobre	15 382	1,274	598	17,254	41,919	59,173
C Regular	13,275	1 217	509	15 002	59 032	74 034
Sub-Total	15,550	1 163	5,325	22 038	45 053	67,092
(= A + B + C)						
D Acceptable	9,525	2,828	6,488	18,841	215 430	234,271
TOTAL	25,076	3 991	11,813	40,880	260 483	301 363

Table A 1 3					
MINSA 1999 DISTRIBUTION OF BUDGET ALLOCATIONS BY DEPARTMENT					
Including the MIPRE Regional Allocations Plus the MINSA Allocations					
	M I N S A T r a n s f e r s				
	Basic Health	Family	Complemen-	Total MINSA	Regional
Department	for All	Planning	tary Food	Transfer	Budget
A Muy Pobre	29%	13%	60%	36%	8%
B Pobre	29%	19%	3%	21%	11%
C Regular	20%	15%	2%	15%	12%
Sub-Total	78%	47%	64%	72%	31%
(= A + B + C)					
D Acceptable	22%	53%	36%	28%	69%
TOTAL	100%	100%	100%	100%	100%

**Table
A 1 4**

MINSA 1999 BUDGET ALLOCATIONS BY DEPARTMENT

Including the MIPRE Regional Allocations Plus the MINSA Allocations

	MINSA Transfers							
	Basic Health	Family	Complemen	Total	Regional	General	MINSA	Popula-
Department	for All	Planning	tary Food	Transfer	Budget	Total	as %	tion
							Total	(000)
Pasco	7 997 094	343,887	135 545	8 476 526	9 524 264	18 000 790	47%	239
Apurimac	10 618 276	489 475	8 011 539	19 119 290	15,983 577	35 102 867	54%	396
Ayacucho	14 045 086	667 693	12 433 825	27 146,604	22 344,000	49,490,604	55%	512
Huancavelica	9 992,915	313 766	9 475,558	19 782 239	10 527,041	30 309 280	65%	400
Cajamarca	15 966 974	1,202 355	5 083 901	22 253 230	27 491 780	49 745,010	45%	1,298
Cusco	16 583 047	1 091 904	23,656,943	41 331 894	47,232 506	88 564 400	47%	1 066
Puno	14 388 007	828 341	17 937 737	33 154,085	45,809,232	78,963 317	42%	1 104
A Muy Pobre	89,591,399	4,937,421	76,735,048	171,263,868	178,912,400	350,176,268	49%	5,015
Loreto	15,818 549	1,071,824	1,949 437	18,839,810	33,407,284	52 247,094	36%	736
San Martin	10 678,227	1 106 965	226,004	12,011 196	24,903,522	36,914 718	33%	572
Huanuco	12,067 019	840,892	206 524	13 114,435	25,401,797	38,516,232	34%	678
Amazonas	5,824 352	745,507	29,067	6,598,926	11 143,861	17 742,787	37%	354
Piura	19,322,691	1 716 925	301,040	21,340 656	40,954,000	62 294 656	34%	1,409
Junin	13 595 663	953 848	441,027	14,990,538	60,386,927	75,377,465	20%	1 093
Ancash	12,311 090	988,989	328,715	13 628 794	48,020,620	61,649,414	22%	984
B Pobre	89,617,591	7,424,950	3,481,814	100,524,355	244,218,011	344,742,366	29%	5,826
Madre de Dios	5 092,691	143 077	68,772	5,304 540	7,822,863	13 127 403	40%	70
Moquegua	2 828 386	190 769	158,905	3 178,060	12,450,364	15,628,424	20%	130
Tacna	5 374 712	409,150	188 893	5,972,755	24 788,642	30,761,397	19%	224
Ucayali	7,550 592	680 244	334 956	8 565 792	23,212 000	31 777,792	27%	332
Tumbes	2 662 602	271,093	64 464	2 998,159	9,006,660	12 004,819	25%	159
Arequipa	12,380,947	1 024 131	369 968	13 775 046	64,461 413	78 236,459	18%	939
Ica	6 687 937	745 507	363 337	7 796 781	42 683 805	50,480,586	15%	579
La Libertad	11,858 342	1 295,225	500 238	13 653 805	61,485 801	75,139,606	18%	1,287
Lambayeque	7 572,039	926 236	329 134	8 827,409	29,826,743	38 654,152	23%	951
C Regular	62,008,248	5,685,432	2,378,667	70,072,347	275,738,291	345,810,638	20%	4,671

Sub-Total	241,217,238	18,047,803	82,595,529	341,860,570	698,868,702	1,040,729,272	33%	15,512
(= A + B + C)								
Lima-Callao	67 885,724	20,154,320	46,242,471	134,282,515	1 535,366,752	1,669,649 267	8%	7,127
D Acceptable	67,885,724	20,154,320	46,242,471	134,282,515	1,535,366,752	1,669,649,267	8%	7,127

Table A 1 5

MINSA 1999 PER CAPITA BUDGET ALLOCATIONS BY DEPARTMENT

Including the MIPRE Regional Allocations Plus the MINSA Allocations

	M I N S A T r a n s f e r s					
	(a)	(b)	(c)	(d)	(e)	(f)
	Basic Health	Family	Complemen-	Total MINSA	Regional	General
Department	for All	Planning	Tary Food	Transfer (=a+b+c)	Budget	Total (=d+e)
Pasco	39,850	1,439	567	35,467	39,850	75,317
Apurimac	40,363	1,236	20,231	48,281	40,363	88,644
Ayacucho	27,432	1,304	24,285	53,021	43,641	96,661
Huancavelica	24,982	784	23,689	49,456	26,318	75,773
Cajamarca	12,301	926	3,917	17,144	21,180	38,324
Cusco	15,556	1,024	22,192	38,773	44,308	83,081
Puno	13,033	750	16,248	30,031	41,494	71,525
A Muy Pobre	17,865	985	15,301	34,150	35,675	69,826
Loreto	21,493	1,456	2,649	25,598	33,836	70,988
San Martin	18,668	1,935	395	20,999	44,409	64,536
Huanuco	17,798	1,240	305	19,343	16,436	56,809
Amazonas	16,453	2,106	82	18,641	115,689	50,121
Piura	13,714	1,219	214	15,146	42,858	44,212
Junin	12,439	873	404	13,715	34,081	68,964
Ancash	12,511	1,005	334	13,850	48,801	62,652
B Pobre	15,382	1,274	598	17,254	41,919	59,173
Madre de Dios	72,753	2,044	982	75,779	111,755	187,534
Moquegua	21,757	1,467	1,222	24,447	95,772	120,219
Tacna	23,994	1,827	843	26,664	110,664	137,328
Ucayali	22,743	2,049	1,009	25,801	69,916	95,716
Tumbes	16,746	1,705	405	18,856	56,646	75,502

Arequipa	13,185	1 091	394	14,670	68 649	83 319
Ica	11 551	1 288	628	13,466	73,720	87,186
La Libertad	9 214	1 006	389	10,609	47,775	58,384
Lambayeque	7,962	974	346	9,282	31,364	40,646
C Regular	13,275	1,217	509	15,002	59,032	74,034
Sub-Total	15,550	1,163	5,325	22,038	45,053	67,092
(= A + B + C)						
Lima-Callao	9,525	2 828	6 488	18,841	215,430	234,271
D Acceptable	9,525	2,828	6,488	18,841	215,430	234,271

Table A 1 6				
THE STABLE DISTRIBUTION				
OF THE MINISTRY OF THE PRESIDENCY'S (MIPRE'S)				
REGIONAL HEALTH BUDGET ALLOCATIONS				
	1993 Allocation		1999 Allocation	
	Regional	Percent	Regional	Percent
Department	Budget	w/o Lima	Budget	w/o Lima
Pasco	2,956 732	2%	9,524,264	1%
Apurimac	3 428,961	2%	15 983,577	2%
Ayacucho	8,320,623	4%	22 344,000	3%
Huancavelica	3,385,047	2%	10 527,041	2%
Cajamarca	6 811,731	4%	27 491 780	4%
Cusco	11,624,354	6%	47 232,506	7%
Puno	13,070,418	7%	45,809,232	7%
A Very Poor	49,597,866	26%	178,912,400	26%
Loreto	9,457,559	5%	33,407,284	5%
San Martin	7,086,986	4%	24,903,522	4%
Huanuco	7,227 417	4%	25 401,797	4%
Amazonas	3,175 839	2%	11,143,861	2%
Piura	9,320,641	5%	40,954,000	6%
Junin	17 117,191	9%	60 386,927	9%
Ancash	12,835 420	7%	48,020 620	7%
B Poor	66,221,053	35%	244,218,011	35%
Madre de Dios	1,811,916	1%	7,822 863	1%
Moquegua	4 053 573	2%	12 450 364	2%
Tacna	6,247 424	3%	24 788,642	4%
Ucayali	5,621,440	3%	23,212 000	3%
Tumbes	2,556,356	1%	9,006 660	1%

Arequipa	17,934,610	9%	64,461,413	9%
Ica	12,214,504	6%	42,683,805	6%
La Libertad	15,395,779	8%	61,485,801	9%
Lambayeque	8,765,525	5%	29,826,743	4%
C Regular	74,601,127	39%	275,738,291	39%
Sub-Total	190,420,046	100%	698,868,702	100%

Table A 1 7						
1999 Ministry of the Presidency Regional Health Allocations						
By Source of Funds Regional Budget and Own-Income						
	1999 CTAR resources				99 CTAR resources	
	Regional	Own			Regional	Own
Department	Budget	Income	Total		Budget	Income
Pasco	7,965,143	2 239,982	10,205,125		78%	22%
Apurimac	13 657,462	1,982,676	15 640,138		87%	13%
Ayacucho	20,671,000	1 400,000	22,071,000		94%	6%
Huancavelica	10,359,259	743,982	11,103,241		93%	7%
Cajamarca	20 965 510	5,769 101	26,734 611		78%	22%
Cusco	30,118,083	9,572,244	39 690,327		76%	24%
Puno	38,906,888	5,252,532	44,159 420		88%	12%
A Muy Pobre	142,643,345	26,960,517	169,603,862		84%	16%
Loreto	31,051,740	8 520,000	39 571,740	C a n o n & S o b r e c a n o n	78%	22%
San Martin	21 959,802	3 381,000	25 340 802		87%	13%
Huanuco	19 548 320	5 052 064	24,600 384		79%	21%

1999 Ministry of the Presidency Regional Health Allocations						
By Source of Funds Regional Budget and Own-Income						
	1999 CTAR resources				99 CTAR resources	
	Regional	Own			Regional	Own
Department	Budget	Income	Total		Budget	Income
Pasco	7,965,143	2 239,982	10,205,125		78%	22%
Apurimac	13 657,462	1,982,676	15 640,138		87%	13%
Ayacucho	20,671,000	1 400,000	22,071,000		94%	6%
Huancavelica	10,359,259	743,982	11,103,241		93%	7%
Cajamarca	20 965 510	5,769 101	26,734 611		78%	22%
Cusco	30,118,083	9,572,244	39 690,327		76%	24%
Puno	38,906,888	5,252,532	44,159 420		88%	12%
A Muy Pobre	142,643,345	26,960,517	169,603,862		84%	16%
Loreto	31,051,740	8 520,000	39 571,740	C a n o n & S o b r e c a n o n	78%	22%
San Martin	21 959,802	3 381,000	25 340 802		87%	13%
Huanuco	19 548 320	5 052 064	24,600 384		79%	21%

1999 Ministry of the Presidency Regional Health Allocations						
By Source of Funds Regional Budget and Own-Income						
	1999 CTAR resources				99 CTAR resources	
	Regional	Own			Regional	Own
Department	Budget	Income	Total		Budget	Income
Pasco	7,965,143	2 239,982	10,205,125		78%	22%
Apurimac	13 657,462	1,982,676	15 640,138		87%	13%
Ayacucho	20,671,000	1 400,000	22,071,000		94%	6%
Huancavelica	10,359,259	743,982	11,103,241		93%	7%
Cajamarca	20 965 510	5,769 101	26,734 611		78%	22%
Cusco	30,118,083	9,572,244	39 690,327		76%	24%
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A Muy Pobre	142,643,345	26,960,517	169,603,862		84%	16%
Loreto	31,051,740	8 520,000	39 571,740	C a n o n & S o b r e c a n o n	78%	22%
San Martin	21 959,802	3 381,000	25 340 802		87%	13%
Huanuco	19 548 320	5 052 064	24,600 384		79%	21%

Amazonas	8 433 253	2 193 846	10,627,099		79%	21%
Piura	38,026,000	9 407 000	47,433,000	C a n o n & S o b r e c a n o n	80%	20%
Junin	37,161,285	16,836,054	53 997,339		69%	31%
Ancash	33,856 278	12 983 249	46,839 527		72%	28%
B Pobre	190,036,678	58,373,213	248,409,891		77%	23%
Madre de Dios	6 880,071	1,403,461	8,283,532		83%	17%
Moquegua	11,903 688	1 710,096	13,613,784		87%	13%
Tacna	17,707,756	3,293,478	21,001,234		84%	16%
Ucayali	18,877 308	4 154,000	23 031,308	C a n o n & S o b r e c a n o n	82%	18%
Tumbes	8 258,985	1 618 443	9,877,428		84%	16%
Arequipa	40 844 873	12 738 250	53,583,123		76%	24%

Ica	29 115,031	7,798,869	36,913,900	79%	21%
La Libertad	38,834 380	17,058,085	55,892,465	69%	31%
Lambayeque	20 216,535	6,000 000	26,216,535	77%	23%
C Regular	192,638,627	55,774,682	248,413,309	78%	22%
Sub-Total	525,318,650	141,108,412	666,427,062	79%	21%
(= A + B + C)					
Note 'C' indicates total Includes Some Financing by the Canon & Sobrecañon Account					